As the lead UN agency in international health development, WHO has been collaborating with its Member States in the South-East Asia Region to strengthen national capacity in several areas of priority interest. Accounting for nearly one fourth of the global population the Region also carries a heavy burden of communicable and noncommunicable diseases. These factors are further compounded by inadequate resources and pose a unique challenge, which are being addressed by policy makers in the Region.

This biennial report on the Work of WHO in the South-East Asia Region for the period 1 January 2008 – 31 December 2009, covers the major areas of WHO collaboration, highlighting the achievements, challenges and the way forward. This report will be found most useful for all those interested in health development in the Region.
Biennial Report of the Regional Director
1 January 2008–31 December 2009
The Work of WHO in the South-East Asia Region

Biennial Report of the Regional Director
1 January 2008–31 December 2009
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Preface

This report on the work of WHO in the South-East Asia Region covers the period from 1 January 2008 to 31 December 2009. Appropriately for a biennial report, it traces the broad outlines of WHO’s collaborative work with the Member States and focuses on key initiatives, accomplishments, issues and challenges.

Every biennium is eventful, but 2008-2009 was particularly so, both within and beyond the health sector. It saw the thirtieth anniversaries of the launching of the primary health care movement and of the eradication of smallpox, and the sixtieth anniversary of the founding of WHO. But along with historic accomplishments came historic challenges, including the global financial crisis, which strained the ability of both individuals and governments to ensure good health. It also saw the first global pandemic influenza in more than 40 years, and put global cooperation and the International Health Regulations—IHR (2005)—to the test. The Region also endured Cyclone Nargis, an earthquake in Sumatra, Indonesia, and other health emergencies. Climate change was prominent on the global agenda, and in terms of its health effects, was a subject of intense concern to WHO and the health ministers of the Region, who adopted the New Delhi Declaration on the Impact of Climate Change on Human Health in September 2008. In September 2009, they adopted the Kathmandu Declaration on Protecting Health Facilities from Disasters.

Collaboration between WHO and the Member States of the Region has been vital to addressing such challenges. These efforts have been conducted through high-level advocacy efforts such as the launching of a campaign to revitalize primary health care at a regional conference in Jakarta in August 2008, and the successful use of the South-East Asia Regional Health Emergency Fund (SEARHEF) to assist Member States in need. However, this important work goes on every day through numerous less visible activities that further the partnership of WHO, the Member States, donors and other stakeholders to strengthen health systems to achieve the Millennium Development Goals and Health for All. Not all of these efforts and initiatives could be mentioned in an overview of the entire biennium; yet these ongoing actions—whether immunization campaigns, polio eradication, development of safe water plans, support for research and epidemiology, or policy development—
are no less extraordinary for being a “routine” part of our work. They rarely make headlines; they always make a difference.

WHO continues to be committed to supporting the Member States in improving the health of their people. The progress they have achieved during this eventful period and against a sometimes unfavourable background deserves to be commended.

Dr Samlee Plianbangchang
Regional Director
Executive summary

1. During the biennium 2008-2009, Member States in the South-East Asia (SEA) Region continued to make progress in health development in spite of a variety of challenges, both regionally and internationally. Collaborative work continued to address many health problems prevalent in the Region, even as new challenges emerged.

Communicable diseases

2. Prominent among the challenges during the biennium was Pandemic (H1N1) 2009 influenza. The pandemic spread rapidly in the Region, as it did throughout the world. WHO worked closely with Member States in the SEA Region for surveillance and rapid response within the context of the International Health Regulations (2005), which came into force in June 2007, and provided advocacy materials in several languages to both alert the public to the threat and to promote healthy behaviours such as hand-washing to combat the disease. Stocks of antivirals, protective gear and other supplies were provided to Member States. The Region benefits from the experience gained from dealing with outbreaks of avian influenza (H5N1), which still lingers in some countries.

3. The need to improve epidemiological skills in Member States was highlighted in 2009. With support from the Regional Office, countries participated in a regional three-month field epidemiology training course; two-week training course on tropical diseases of public health importance, and in several hands-on workshops aimed at improving influenza surveillance, diagnostic capabilities and the ability to respond rapidly.

4. Tuberculosis still claims half a million lives in the Region each year. However, countrywide DOTS services have been sustained in all 11 Member States. In 2009, the Region reached 85% treatment success, thereby averting 300 000 deaths. Member States were supported in mobilizing resources for TB control from donor governments and international agencies.

5. The South-East Asia Region carries the third-highest HIV burden in the world. There are 3.5 million people living with HIV in the Region. Although 0.3% of the adult population is infected with HIV, infection
rates are much higher among high-risk groups. Progress has been made in targeted interventions for these groups; the 100% condom promotion programme has led to increased condom use among sex workers and approximately 25% reduction in HIV prevalence among female sex workers. In addition, the WHO Regional Offices for South-East Asia and the Western Pacific developed a biregional toolkit to assist national programme managers to monitor and develop more effective services for sex workers. Based on the five strategic directions (increasing knowledge of HIV status; HIV prevention through the health sector; HIV/AIDS treatment and care; health systems strengthening; and HIV strategic information), WHO focused on scaling up HIV/AIDS prevention, treatment, care and support during the biennium.

6. All malaria-endemic countries have revised/updated their national strategies in line with the revised malaria control strategy for the SEA Region 2006-2010. The reported number of malaria cases and deaths in 2008 were 2.5 million laboratory-confirmed cases and 30228 deaths, respectively. Compared with 2006, the reported deaths in the Region in 2008 decreased by 29.5%. Drug resistance is a continuing challenge, especially with the problem of newly emerged artemisinin resistance.

7. Only one country has yet to achieve the global leprosy elimination target (a prevalence rate of fewer than 1 per 10 000 population). However, during 2008, 67% of the global total of new cases were detected in the South-East Asia Region. The Global Strategy for Further Reducing Leprosy Burden and Sustaining Leprosy Control Activities 2006-2010 was adapted and implemented in all endemic countries globally.

8. Nearly 66% of the global estimate of 1.3 billion people at risk for lymphatic filariasis (LF) are in the South-East Asia Region. To address the disease burden, a Strategic Plan for the Elimination of LF in the SEA Region 2010-2015 was developed. All nine endemic countries in the Region have adopted the WHO-recommended two-drug strategy for mass drug administration. With regard to kala-azar, the health ministers of the three endemic countries (Bangladesh, India and Nepal), have committed to reaching the elimination target by 2015.

9. Although there has been an increase in the number of cases of dengue in the Region, there has been a decrease in the number of deaths, due to better case management. The biregional Asia-Pacific Dengue Strategic Plan (2008-2015) was developed to provide guidelines for the establishment of national plans to combat the disease and endorsed by programme managers of both the SEA and Western Pacific regions.
10. The regional capacity to diagnose influenza and other emerging pathogens was enhanced during the 2008–2009 biennium. Networks for several pathogens are being forged to ensure regional self-reliance. The Asia Pacific Strategy for Strengthening Health Laboratories is being utilized in comprehensively addressing laboratory issues in countries. The WHO Global Strategy on Safe Blood has been adopted by all Member States. A regional strategy for prevention and containment of antimicrobial resistance was developed and shared with all Member States.

**Noncommunicable diseases and social determinants of health**

11. The Region continues to undergo sociocultural, economic and demographic changes that result in the growth of noncommunicable diseases (NCDs). Chronic NCDs such as cardiovascular diseases, cancer, chronic lung diseases and diabetes account for 54% of all deaths in the SEA Region, and nearly half of the total disease burden. Efforts are being made to provide support to Member States to strengthen their national capacity for formulation, implementation and evaluation of policies, plans and programmes for the integrated prevention and control of NCDs.

12. The Regional Office developed a strategy to deliver essential mental health care to all persons needing such care, including those in rural and remote areas. Harm from alcohol use is a major concern in several Member States. All Member States contributed to the draft WHO global strategy to reduce the harmful use of alcohol.

13. Tobacco use is responsible for more than 1.2 million deaths annually in the SEA Region. Support was provided to Member States to implement tobacco control measures in line with the WHO Framework Convention on Tobacco Control (FCTC). Efforts have been made to standardize adult tobacco surveillance in the Region, and Global Adult Tobacco Surveys (GATS) were conducted in Bangladesh and Thailand. Efforts were made to implement the MPOWER policy package, as well as the guidelines developed by the Conference of Parties for effective implementation of the WHO FCTC. Tobacco control efforts are also being supported mainly in four Bloomberg Initiative focus countries in the Region.

14. WHO has been advocating and supporting Member States to increase political, financial and technical commitment in injury prevention. Awareness of the Convention on the Rights of People with Disabilities has been raised through outreach activities. The First
Asia-Pacific Congress on Community-based Rehabilitation (CBR) was organized by WHO and partners to highlight innovative activities and the need for research in CBR. A comprehensive situation analysis on VISION 2020 and a draft five-year plan (2010-2014) for prevention of deafness and alleviation of hearing impairment for the Region was developed. Assessment of epidemiology of hearing loss has begun in all Member States and a regional symposium on infant hearing screening was conducted.

15. The *Regional Strategy for Health Promotion for South-East Asia* has been a key document to provide a strategic guideline and framework for countries of the Region to develop human resources for health promotion from various professions and to bring about a multisectoral approach for interventions. School health promotion is a key element. Member States were supported in conducting Global School Health Surveys (GSHS), which provided important evidence for formulating strategic planning and interventions for school health promotion programmes.

**Family health and research**

16. The year 2008 marked the thirtieth anniversary of Alma Ata Declaration on Primary Health Care (PHC). A Regional Conference on revitalizing PHC was held in Jakarta in August 2008. In response to the regional consensus to revitalize PHC, the Primary and Community Health Care unit was created in the Regional Office in June 2009. Thailand was supported to develop the Strategic Route Map (SRM) – a tool to empower the community in health development. Senior officials from Bangladesh, India, Indonesia, Sri Lanka and Thailand were also oriented to SRM. Bangladesh was supported in expanding the Community Health Clinics to strengthen community-based services. A regional PHC Innovations Network was established to promote the exchange of ideas on PHC.

17. Lack of access to key maternal and newborn health (MNH) care continues to be a major issue in the Region. Member States are accepting family planning, skilled care at birth, emergency obstetric care and essential newborn care as the main interventions for reducing maternal and neonatal mortality. The Regional Committee in 2008 urged Member States to develop a long-term national plan on human resources for MNH.

18. The elements of reproductive health include MNH, family planning, and prevention of unsafe abortion and sexually transmitted infections
(STIs), which are interrelated and therefore need an integrated approach. The regional framework for implementing the WHO-recommended Reproductive Health Strategy was developed and countries assisted in its adaptation and implementation. Technical support was given to strengthen family planning programmes, expand contraceptive choice and quality of services, prevention of unsafe abortion, increasing research capacity, and monitoring progress towards achieving universal access to reproductive health. Collaborative activities were carried out on the integration of prevention and management of STIs/HIV infection into reproductive health services and resource mobilization.

19. In the area of nursing and midwifery, the focus was on education, MNH, workforce planning and management, as well as nursing and midwifery services and regulation. The South-East Asia Nursing and Midwifery Educational Institution Network (SEANMEIN) has provided a platform for experience-sharing. Member States were supported in their effort to improve quality of midwifery training and MNH services.

20. Adolescents (10–19 years) make up about 25% of the total population of the Region. Members States have adopted a four-part strategic framework to strengthen health sector response to the needs of adolescents, namely strategic information, a supportive policy environment, services and supplies, and greater collaboration with other sectors. WHO provided technical support in these areas. In terms of child health, WHO's support to Member States focused on the achievement of Millenium Development Goal 4. Integrated management of childhood illness (IMCI) remains the main vehicle to promote child health. Scaling-up of implementation to cover additional geographical areas has been achieved in seven Member States.

21. A regional strategic framework for improving and sustaining immunization coverage was drafted and circulated among all stakeholders. In the area of vaccine supply and quality, the focus was on strengthening national regulatory capacity and preparing the Regional Working Reference Standards (RWRS).

22. At the end of 2009, India remained the only polio-endemic country in the Region. However, the number of infected districts was reduced by a third compared to 2008. An independent evaluation confirmed the high quality of polio surveillance. In polio-free countries of the Region, the challenge remains to maintain high levels of OPV immunization through routine immunization as well as to sustain high-quality surveillance of acute flaccid paralysis (AFP). A regional measles consultation held in August 2009 recommended the goal of measles elimination by 2020. Overall, the Region achieved measles
routine immunization coverage of about 75%. To further strengthen immunization practices and systems, ten Member States in the Region were assisted to establish national advisory committees for immunization practices.

23. The emerging issue of increasing food prices and their impact on nutrition and food security was the focus of several activities. Technical assistance in understanding and formulating food safety and security interventions in response to the impact of climate change on food production, availability and consumption was provided to six Member States. Iodine deficiency disorders (IDD) continue to be a public health concern in the Region. Development of national IDD control programmes was supported in Member States.

24. The proportion of population aged 60 years and above is increasing in all Member States of the Region. It is estimated that by 2050, in over half of the Member States, 20% or more of the population will be 60 years old or over. SEARO organized a regional consultation on a strategic framework for active healthy ageing in 2009. The principal objective was to provide technical support to the Member States in developing and implementing policies and programmes for active healthy ageing and old age care.

25. The Thirty-first session of the SEA Advisory Committee on Health Research was held in July 2009. A draft regional and national strategy for research for health was developed. WHO supported the research ethics and ethics review committee (ERC) capacity of Member States through a series of international training courses. WHO also supported annual meetings of the Forum for Ethical Review Committees in Asia and the Pacific (FERCAP) in 2008 and 2009.

**Sustainable development and healthy environments**

26. WHO focused on building community resilience to the impact of climate change. At their Twenty-sixth Meeting in September 2008 in New Delhi, the Ministers of Health of the South-East Asia Region adopted the New Delhi Declaration on the impacts of climate change on human health. Climate change and human health was also the subject of the 2008 World Health Day; WHO-SEARO produced a range of advocacy material to raise public awareness and sensitize all sectors to this cross-cutting issue.
27. WHO provided assistance to Member States of the Region to improve the health of workers, to develop occupational health policy, assess national capacity in occupational health, and train health workers on awareness and skills to provide community-based occupational health services. A baseline study was undertaken in ten Member States to assess their readiness to implement the recommendations of the Global Strategy for Occupational Health for All and the Global Plan of Action for Workers’ Health. Steps were taken toward the establishment of a Chemical Helpdesk for the Region.

28. The Regional Office was involved in a number of global health partnerships. Collaboration with international and national NGOs was strengthened in several areas. Emerging trends in donor funding included the rise in official development assistance (ODA) in 2008 and a larger share of ODA for the health sector, more decentralization of donor funding at country level and new funding mechanisms.

29. Voluntary Contributions (VC) in the regional Programme Budget for 2008-2009 increased by 50% compared to the biennium 2006-2007. In absolute terms, VC increased from US$ 291.9 million to US$ 439.1 million. This presented a challenge, especially at a time of global financial crisis. In order to achieve this target, the regional and country offices stepped up resource mobilization activities with improved strategies and approaches and concluded 142 funding agreements with 43 donors and partners. In spite of the rising challenges in resource mobilization, including the global financial crisis, the total amount of voluntary contributions mobilized at the end of 2009 was $322 million. It is important to note that voluntary contributions were made for the first time by some Member States in the Region, which contributed for the strengthening regional solidarity.

30. Awareness and knowledge about safe drinking-water was substantially increased in Member States through various regional and national workshops and trainings. Foundations for scaling up the introduction of water safety plans were laid through the preparation of guidelines, manuals and strategies. Drinking water quality monitoring and standards were strengthened.

31. Promotion of sanitation was achieved through workshops and high-level conferences. Pilot projects to test the appropriateness of ecological sanitation options were carried out. Capacity to manage health-care waste was strengthened in Member States through regional and national training programmes. Various advocacy materials on water and sanitation were produced and disseminated in the Region.
32. In the area of emergency and humanitarian action, WHO responded to events such as Cyclone Nargis in Myanmar in May 2008, the post-conflict humanitarian situation in Sri Lanka starting in May 2009, and a major earthquake in Sumatra, Indonesia, in September 2009. Member States were supported through the South-East Asia Regional Health Emergency Fund (SEARHEF) and other preparedness activities. The South-East Asia Disaster Health Information Network (SEADHIN) was also set up to improve proper collection, archiving and retrieval of information related to disasters and health.

33. The focus of World Health Day 2009 was the need to keep health facilities safe in emergencies and disasters. In September 2009, health ministers adopted the Kathmandu Declaration on Protecting Health Facilities from Disasters. This declaration will guide the work of WHO-SEARO in this important area.

34. Efforts toward improving health information management and dissemination continued. All WHO publications in hard copy are made available, free of charge, through Depository Libraries and Reference Libraries of WHO publications at Member States. During the period nine additional reference libraries have been established, one reference library each in Bangladesh, Bhutan, DPR Korea, Myanmar and Timor-Leste, and two libraries each in India and Thailand. A regional network of medical councils was established to promote intercountry cooperation in promotion of ethical medical practice.

**Health systems development**

35. The global financial crisis of 2008-2009 gave further prominence to health financing as a key to protecting the health and development needs of the poor. WHO-SEARO continued its direct support to countries as well as capacity development at the regional level in health economics and financing. In collaboration with local institutes, the health and related ministries, health financing and expenditure reviews were initiated to assess policy needs and options to improve equity and efficiency.

36. SEARO reviewed its own Biregional Health Financing Strategy 2011-2015 with WPRO based on inputs from countries and development partners. The strategy has been aligned with the Organization’s recent work on primary health care and social determinants of health.

37. A regional consultation for self-care was convened in Bangkok Thailand in early January 2009, which recommended that Member
States include strengthening of self-care as a programme in their efforts to revitalize PHC.

38. A rapid assessment guideline for health systems strengthening was developed using a team approach for extending technical assistance to countries. The South-East Asia Public Health Education Institutions Network (SEAPHEIN) was supported by WHO in such areas as accreditation.

39. Promoting public health to improve health equity is an ongoing priority. The challenges to health systems include a shortage of capable district health managers, the need to enhance the competency of community-based health workers and community-based volunteers, and improvement in the organization and management of health services delivery. WHO is working in close collaboration with the countries in their capacity building for a sustained health workforce (HWF) development.

40. Bearing in mind the importance of HWF strategic planning, Regional Guidelines for Development of Health Workforce Strategic Plans in Countries of the South-East Asia Region were developed, which identify and define different types and categories of HWF.

41. Medicines are an essential component of health care systems and their management requires many different functions including regulation, selection, procurement, supply and rational use. An innovative “Patent Pool” is being developed globally by UNITAID in cooperation with the pharmaceutical industry. The first (and so far only) regional meeting on the Patent Pool was held in SEAR in June 2009. Eight SEAR countries participated in the 13th International Conference of Drug Regulatory Authorities (ICDRA) in November 2009, which was supported by all levels of WHO.

42. Traditional medicine (TM) is widely used in the Region. To develop evidence-based information on quality, safety or efficacy of TM products, exchange of information and inter-institutional cooperation was initiated. A list of traditional medicine departments, teaching, health-care service and research institutions was established. TM pharmacopoeias and national formularies were exchanged. To facilitate this process, a website called HerbalNet was set up.

43. The potential impact of intellectual property rights—notably patents—on access to medicines remains an issue of concern. WHO focused on providing information, increasing awareness and knowledge, and strengthening capacity in Member States to analyse and address the public health implications.
44. The development of a gender mainstreaming Plan of Action (POA) 2009–2013 in health for the South-East Asia Region was finalized in the Inter-working Group on Gender Mainstreaming in Health (IWGGM) in the Regional Office. To support gender mainstreaming in the Region, during 2009 multisectoral guidelines on gender-based violence (GBV) primary prevention were developed.

45. The Regional Programme on Health Situation and Trend Assessment: Strengthening Country Health Information for 2008-2009 was developed in response to recommendations of the Sixtieth Session of the Regional Committee for South-East Asia.

46. A SEARO Task Force for monitoring the achievement of health-related MDG in the Region has been established. It submitted reports to the Health Ministers’ Meeting in 2008 and reported on follow-up actions in 2009.

47. Implementation of norms and standards in the area of patient safety progressed during the biennium. Over 500 hospitals in the Region were registered to implement the WHO Hand Hygiene Toolkit by the end of June 2009.

Policy and programme planning

48. The annual meetings of the Ministers of Health from Member States of the South-East Asia Region adopt a declaration on the World Health Day theme of that year. The Twenty-sixth Meeting of the Health Ministers in September 2008 adopted the New Delhi Declaration on the health impacts of climate change and health; the Twenty-seventh meeting in September 2009 adopted the Kathmandu Declaration on Protecting Health Facilities from Disasters.

49. Support from WHO to countries in the Region continued to be provided through a country-specific approach. Country Cooperation Strategies (CCS) finalized in consultation with Member States reflect the priorities for WHO support to each country over a period of four to six years. During the reporting period the CCS documents were finalized for Bangladesh, Myanmar, Thailand and Timor-Leste. The ultimate goal of WHO’s collaboration with countries continues to be the strengthening of country capacity for long-term sustainable health development.

50. During the biennium WHO resources and activities were further decentralized to country level. More national staff were involved in
the implementation of WHO programmes at both country and regional levels, and more country expertise in the Region was utilized in WHO work. The Sixty-first Session of the Regional Committee for South-East Asia was held in the Regional Office, New Delhi, India, on 8-11 September 2008, while the Sixty-second Session was held in Kathmandu, Nepal, on 7-10 September 2009. Besides representatives of all the 11 Member States of the Region, the Director-General and representatives of other UN agencies, NGOs having official relations with WHO and observers attended the sessions. Six resolutions and three decisions were adopted in the Sixty-first Session and seven resolutions and three decisions in the Sixty-second Session.

**General management**

51. During the biennium, preparations were made for the roll-out of the Global Management System (GSM) on 1 January 2010. The GSM is a tool to increase the efficiency of the work of the Organization, and particularly the management of its collaborative activities with Member States.

52. The Region continues to strengthen capacity to support country offices towards effective financial management of programme implementation. At the end of the biennium, the Region had fully committed its Assessed Contributions allocation of US$102.9 million and had expended US$ 260.3 million of Voluntary Contributions. Remaining challenges include effective monitoring and implementation of VC, strengthening competencies in GSM and enhancing adaptability to unpredictable and frequently specified VC funding.
Communicable diseases

Communicable diseases surveillance and response

1. Under the new International Health Regulations (IHR) 2005, which came into effect in June 2007, the World Health Organization has explicit obligations for safeguarding international public health security. In March 2009, an outbreak of febrile respiratory illness was reported from Mexico, followed by similar cases in the United States. In April 2009, a new influenza A (H1N1) virus was confirmed. The outbreak spread rapidly to other parts of the world, and on 25 April 2009, the WHO Director-General declared
an influenza pandemic—the world’s first ever public health emergency of international concern (PHEIC) since the entry into force of IHR (2005).

2. The WHO Regional Office for South-East Asia (SEARO) provided support and guidance to Member States to rapidly detect, verify and mount a response to the pandemic that balanced the interests of travel and trade with public health concerns. It activated the Strategic Health Operations Center (SHOC) to coordinate emergency response, including timely sharing of information and technical guidance and logistics support to Member States. In July 2009, SEARO organized a regional consultation on Pandemic Influenza A (H1N1) 2009 to review the situation and agree on a unified approach for strategic actions to strengthen national capacity in response to the pandemic. By the end of 2009, a total of 61 000 cases and 1290 deaths had been reported from the Region. However, the real magnitude of the pandemic still remains largely unknown.

3. Human infections of highly pathogenic avian influenza A (H5N1) were reported from Indonesia, posing the potential for reassortment with Pandemic (H1N1) 2009 virus. Outbreaks of A (H5N1) in poultry were also reported in the Region, including from Bangladesh, India Indonesia and Nepal. In view of these continued threats, improving capacity for detection, risk assessment and response to outbreaks and other emerging disease threats, risk communication, and enhancing intersectoral collaboration were the focus of activities of the Regional Office.

4. Increased emphasis was put on improving epidemiological capacity in Member States. With support from the Regional Office, a total of 12 medical officers from seven countries completed a three-month Regional Field Epidemiology Training course organized at the National Centre for Disease Control (NCDC), Delhi, India. Training modules for a two-week training on tropical diseases of public health importance were developed, and 15 medical officers and physicians from nine countries were trained in collaboration with NCDC and the Faculty of Tropical Medicine (Mahidol University, Thailand). Technical support was provided to conduct a four-week regional training on prevention and control of communicable diseases for nine paramedical workers from India. The Regional Office participated in training of more than 200 field personnel supported by the WHO India country office on epidemic
and pandemic response. Moreover, the Regional Office supported several hands-on workshops including on early warning and response and on risk assessment and management. More than 100 personnel from Bhutan, India, Maldives, Nepal and Sri Lanka were trained on infection control.

5. Disease outbreaks including acute encephalitis syndrome, dengue fever, leptospirosis and meningococcal meningitis were reported from the Region. Outbreaks of acute watery diarrhoea, which includes cholera and other enteric infections, are widespread. In 2009, an outbreak of cholera in Nepal caused more than 71 000 cases and 371 deaths. In Bangladesh more than 2.6 million cases and 360 deaths were recorded. Outbreaks of acute diarrhoea were also reported from India. These outbreaks highlight the necessity to strengthen surveillance, reporting and laboratory capacity for early case detection, as well as the need for improving access to safe drinking water, proper sanitation, use of proven interventions and appropriate case management. SEARO and WHO country offices jointly provided support to Member States in responding to outbreaks including verification, deployment of experts, providing regular guidance, assistance with coordination of response and mobilization of emergency drugs and supplies.

6. The Regional Office has taken important initiatives to address the problem of acute diarrhoea and respiratory infections. A Technical Advisory Group was established, and in consultation with experts from Member States, a Regional Strategic Framework for prevention and control of acute diarrhoea and respiratory infection was developed. Advocacy work, including publications in journals and presentations at seminars and workshops, was also conducted.

7. Critical issues to be addressed include continued development and strengthening of event-based and indicator-based surveillance, improving the timeliness of reporting from traditional surveillance systems, and providing support to Member States to strengthen core capacities for implementing IHR (2005), including at designated points of entry to protect public health. Developing national and subnational risk assessment capacity and creating links with other key departments beyond infectious diseases—such as food safety, chemical, animal and radiological units—will be important to achieve the Organization’s mandate under the IHR (2005).
HIV/AIDS and sexually transmitted diseases

8. Based on the five strategic directions (increasing knowledge of HIV status; HIV prevention through the health sector; HIV/AIDS treatment and care; health systems strengthening; and HIV strategic information), the HIV unit focused on scaling up HIV/AIDS prevention, treatment, care and support. Box 1.1 and Figure 1.1 reveal the current situation of HIV infection in the South-East Asia Region.

**Box 1.1: HIV infection in the South-East Asia Region**

Nearly 3.5 million people are living with HIV in the Region, of whom 33% are women. Overall, HIV prevalence among the adult population is low (0.3%), but the Region has the third-highest HIV burden in the world after sub-Saharan Africa and the Americas, and accounts for 10% of all people living with HIV globally. Five countries account for the majority (>99%) of HIV infections—India, Indonesia, Myanmar, Nepal and Thailand.

**Figure 1.1: HIV prevalence in adult populations, South-East Asia Region, 1990–2008**

Source: HIV prevalence for each country was generated by Spectrum model using surveillance data reported by national AIDS programmes.

9. Country capacity for HIV counselling and testing was strengthened through training in HIV counselling. Approximately 10 million people were tested across the Region in 2008.

10. Eight out of the 11 Member States have a national policy on HIV testing and counseling.
11. The percentage of the population with high-risk behaviour accessing counselling and testing also increased during the biennium.

12. The 100% targeted condom promotion programme led to increased condom use among sex workers and approximately 25% reduction in HIV prevalence among female sex workers.

13. SEARO and the Regional Office for the Western Pacific (WPRO) developed a biregional toolkit focusing on HIV services for sex workers. The toolkit is designed to assist national programme managers to monitor and develop more effective services for sex workers. The Regional Strategy for the Elimination of Congenital Syphilis (ECS) was developed to assist countries. Clinical and operational guidelines on the management of opioid dependence and common health problems among drug users were developed and disseminated to all Member States and partners. National staff capacity on care and treatment of HIV-positive IDUs was strengthened in select Member States.

14. All Member States (with the exception of DPR Korea, where HIV is not yet reported) in the Region are working to provide comprehensive HIV treatment, care and support to all those in need.

15. Following a tremendous scale-up of antiretroviral therapy among Member States, 443 000 people with advanced HIV infection are currently receiving antiretroviral treatment (ART). Of those started on ART, 65% to 82% were alive and on treatment a year after the start of therapy (Figure 1.2). Ten of the 11 Member States of the Region have national guidelines based on the WHO clinical manual on Management of HIV Infection and Antiretroviral Therapy in Adults and Adolescents and free national ART programmes in which standardized first-line ART is delivered using the public health approach. WHO provided technical assistance to India to develop and evaluate second-line ART operational and technical guidelines. Mechanisms for collaboration between HIV and TB programmes have been set up in all Member States.

16. All Member States have guidelines on co-trimoxazole prophylaxis for HIV-infected persons. The Regional Office provided support in expansion and improvement of ART monitoring and evaluation through training on the recording and reporting system using the ART training toolkit.

17. SEARO produced guidelines for conducting a review of the health sector response to HIV/AIDS to assist Member States to assess the achievements of the national AIDS programmes and provide recommendations for improving strategies and interventions.
18. An intercountry workshop on human resource planning was conducted in Bhutan in 2008 to identify human resource gaps in the context of national HIV/AIDS programmes. An orientation package for potential STI consultants was developed and training was conducted with the objective of building a roster of STI consultants in the Region. Direct technical support was provided to countries for the development of proposals for the Global Fund. Peer review of Global Fund proposals was held in the Regional Office in 2008 to review and technically strengthen the proposals. Around US$ 573 million was mobilized for HIV for Member States through the Global Fund for AIDS, TB and Malaria during 2008–2009. National programme staff in all countries and HIV focal points in WHO country offices were trained in AIDS programme management using the SEARO training modules. Some high HIV-burden countries, including Nepal and Thailand, have adapted SEARO training modules, and 30 subnational AIDS programme managers have been trained in each country.

19. Key components of HIV strategic information include: surveillance of HIV, sexually transmitted infections and risk behaviours; HIV drug resistance surveillance; programme monitoring; and evaluation and research. Capacity for second-generation surveillance improved in 10 out of 11 Member States through training at the regional level.

20. All countries (except DPR Korea) have conducted HIV serological surveillance. HIV behavioural surveillance was conducted in 10 of 11 Member States in 2009 compared to six in 2005. HIV drug resistance activities were initiated in three high HIV-burden countries—India, Indonesia and Thailand. Capacity for HIV estimates and projections
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improved in 10 of the 11 Member States. Regional ART monitoring tools were developed and implemented in six countries. Evaluation of the HIV surveillance system was conducted in six of the 11 Member States of the Region.

21. While great progress has been made, a number of challenges remain. These include widespread HIV-associated stigma in communities and discriminatory practices in health-care settings; weak health systems; the high cost of antiretroviral drugs; lack of vital information on high-risk populations; and inadequate coordination among multiple agencies involved in implementing HIV interventions.

Tuberculosis

22. Tuberculosis (TB) remains one of the most serious health and development problems in the South-East Asia Region, which continues to account for over a third of the global TB burden, with an estimated 3.2 million new cases of TB occurring each year. Of the 3.6 million people living with HIV in the Region, roughly half are estimated to be coinfected with TB. Levels of multidrug resistance (MDR), fortunately, are still low at under 3% among new TB cases. However, this translates into nearly 180 000 new MDR-TB cases each year.

23. The trends of estimated prevalence, incidence and mortality rates in the SEA Region as a whole are presented in Figure 1.3. Estimates for TB prevalence were halved; mortality reduced by a third, and a steady decline in incidence was maintained in the Region.

Figure 1.3: Trends in estimated prevalence, incidence and mortality rates of TB in the SEA Region, 1990–2008

Source: SEAR TB Annual Report 2010
24. Bangladesh, India, Indonesia, Myanmar, Nepal and Timor-Leste were supported to expand MDR-TB case management under their national TB programmes, while Bhutan, Sri Lanka and Thailand were assisted in developing proposals and plans to begin activities. Nearly 1500 patients with MDR-TB were registered for treatment under national programmes by December 2009.

**Box 1.2: TB scenario in the Region**

Each year more than two million TB cases are being registered for treatment and over 85% of them are successfully treated, thereby averting over 300 000 deaths from TB every year in the South-East Asia Region.

25. Technical assistance was provided to accredit national reference laboratories in seven countries for TB culture and drug susceptibility testing (DST). As a result, eight countries (all except DPR Korea, Maldives and Timor-Leste) have culture and DST facilities at the national level. All Member States were supported in their efforts to further expand interventions for TB/HIV. These are currently available countrywide in Thailand, and are being rapidly expanded in India, Indonesia and Myanmar. As a result, a comprehensive package of interventions for HIV-associated TB was made available to 600 million of the Region’s population by December 2009.

26. WHO supported several national training sessions as well as workshops held at three WHO collaborating centres—the TB Research Centre in Chennai, India; the National TB Institute, Bangalore, India; and the SAARC TB-HIV Centre in Kathmandu, Nepal. Regional workshops to build capacity in the areas of health systems strengthening; strengthening laboratory capacity for TB diagnosis; respiratory infection control; managing multidrug-resistant TB; and improving TB surveillance,
monitoring and evaluation, were organized. A joint meeting of TB and HIV/AIDS programme managers was also held.

27. Impact assessments and improvement in data management, including for better use of routine programme data, were supported in Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal and Thailand.

28. WHO promoted public-private partnerships in TB control. Over 360 medical colleges, 22,000 private practitioners, 1,500 large public and private hospitals, 150 corporate institutions, 2,500 nongovernmental organizations and 550 prisons are now working in collaboration with national TB control programmes. A number of community-based approaches are also being incorporated into routine service delivery by the national programmes.

29. The Regional Office and country offices supported the submission of funding proposals to mobilize additional funding for TB control through donor governments and international agencies including the Global Fund in all Member States and the 3-Diseases Fund in Myanmar.

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**Box 1.3: Challenges in TB control**

- Overstretched national public health care systems: gaps in human resources, surveillance and monitoring, procurement and logistics management systems;
- Inadequate national laboratory capacity (including for TB cultures, drug sensitivity testing, and deployment of newer faster diagnostics);
- Limited capacity for programme management, particularly of drug-resistant TB and TB/HIV;
- Provision of health care in other sectors not yet fully linked to national programmes;
- Low community awareness and utilization of services;
- Unregulated over-the-counter sales of TB drugs in many countries;
- Limited availability of quality assured second-line drugs; small number of pre-qualified manufacturers; delays in procurement;
- Uncertain long-term funding, particularly for MDR-TB; the Region lacks an estimated one third of funding required for TB control until 2015.
Malaria

30. All malaria-endemic countries have revised/updated their national strategies in accordance with the Revised Malaria Control Strategy for the SEA Region 2006-2010, which was endorsed by the Sixtieth Session of the Regional Committee for South-East Asia in 2007. Member States successfully introduced and scaled up key interventions such as rapid diagnostic tests (RDTs) to supplement microscopic diagnosis and clinical diagnosis. All malaria-endemic countries that reported falciparum malaria adopted artemisinin-based combination therapy as the first-line treatment for uncomplicated falciparum malaria. All malaria-endemic countries introduced long-lasting insecticidal nets (LLIN) as the key intervention for prevention of malaria and applied indoor residual spraying in high to moderate transmission areas.

31. The cumulative coverage of mosquito nets (all types, including LLIN and untreated nets) increased from 16.3 million in 2006 to 27.7 million in 2008, covering approximately 16.5% of the population at high and moderate risk. During the same period, 31% of the high-risk population was covered by indoor residual spraying.

32. A step-by-step approach for implementing integrated vector management (IVM) at district level was disseminated. Three Member States (India, Indonesia and Sri Lanka) have already initiated IVM for malaria control.

Figure 1.4: Population at high and moderate risk of malaria covered under bednets* (cumulative) in the SEA Region, 2005-2008^
The reported number of malaria cases and deaths in 2008 were 2.57 million laboratory-confirmed cases and 3228 deaths, respectively. The absolute number of laboratory-confirmed cases in 2008 increased by 4.9% compared to 2006 due to outbreaks in some countries and increased activity in case detection with donors’ support. The reported deaths have continued to decline since 2000 in most countries except Indonesia. As compared to 2006, the reported deaths in the Region in 2008 had fallen by 29.5%. Bangladesh, Bhutan, Nepal, Thailand and Timor-Leste have shown more than a 50% decline in reported malaria deaths.

Artemisinin-resistant falciparum was reported at the Thai–Cambodian border in 2006-2007. In January 2009, a two-year project on containment of artemisinin resistance was initiated by WHO with financial support from the Bill and Melinda Gates Foundation and the participation of various technical partners. The project was coordinated and technically supported by the Mekong Malaria Programme. National and international task forces were established to review the progress of the control strategies. Evidence of potential spreading of artemisinin resistance from the Thai–Cambodian border to Myanmar (at the southern border with Thailand and northern border with the People’s Republic of China) was observed. This necessitated intensifying and strengthening of drug-resistance monitoring in other countries of the SEA and the Western Pacific regions.

Technical support was provided to Bangladesh, Indonesia and Timor-Leste to develop national capacity in data management. Bangladesh was provided support for GIS application.

Technical support was also provided for two annual international training courses on clinical management of malaria organized in collaboration with the WHO Collaborating Centre for Clinical Management of Malaria. WHO supported the Asian Collaborative Training Network for Malaria (ACTMalaria) initiative by providing technical support to conduct an international course on management of malaria field operations in 2009.

World Malaria Day (25 April) was successfully commemorated by Member States for the first time in the SEA Region in 2008 and also in 2009. Malaria campaigns, technical seminars and advocacy activities were organized.

Member States with low endemicity (Bhutan, DPR Korea, Sri Lanka and some parts of India and Indonesia) participated in the newly established Asia Pacific Malaria Elimination Network (APMEN),
which had its inaugural meeting in February 2009. The main outputs included information sharing, resource mobilization and identified research priorities on vivax malaria.

**Figure 1.5:** Laboratory-confirmed malaria cases and deaths in the SEA Region, 2000-2008

![Laboratory-confirmed malaria cases and deaths in the SEA Region, 2000-2008](source: Country Reports, 2008)

39. Collaboration between DPR Korea, the Republic of Korea and the People’s Republic of China on controlling vivax malaria was further strengthened. A biregional meeting was organized in April 2009 to review the progress made in vivax control at the southern border of DPR Korea. Border collaboration between Bhutan and some states of India was established through a meeting held in 2009.

**Global Fund grants: improving access and implementation**

40. During 2008-09, US$ 1.8 billion was mobilized through Round 7, 8 and 9 Global Fund proposals. The ratio of allocation between the government and non-government sector was 60% and 40% at the Principle Recipient level. Nearly US$ 700 million of these funds were allocated for activities related to health system strengthening (HSS) and US$ 16 million for WHO’s technical assistance to countries for the implementation of HIV, TB and malaria activities supported through the Global Fund grants.
41. WHO continued to assist Member States in proposal development, grant negotiation, support for implementation, monitoring, evaluation and constituency matters. Mock Technical Review Panels were constituted to help review and strengthen the country proposals prior to submission during the Round 8 and Round 9 call for applications. The Regional Office briefed the Global Fund board members from the South-East Asia Region constituency, prior to the 18th Global Fund Board Meeting in November 2008, and supported the South-East Asia Region Constituency meeting in Bangkok in April 2009, ahead of the Board Meeting in May 2009.

42. In assisting countries, the WHO focus has been to develop capacity of the countries. With every call for proposals, starting in 2006, WHO-SEARO has held capacity-building workshops. In February 2008, a workshop on grant negotiation and implementation was organized to develop capacity in efficient implementation and facilitate the early signing of approved Round 7 Global Fund grants. The Workshop on Global Fund Round 8 Proposal Development (March 2008) ensured that Member States had the skills to develop technically sound proposals in compliance with new Round 8 proposal guidelines. Consultants were deployed to assist countries with the development of technically sound proposals for all rounds. Three technical meetings were jointly organized by the Global Fund and WHO with both government and civil society partners in the SEA Region during 2009. Nine countries
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are successfully implementing grants through civil sector Principal Recipients and sub-recipients.

43. A review and assessment of the usefulness and impact of WHO support in relation to Global Fund grants to countries was conducted. The findings show that, although countries continue to face a range of significant challenges throughout the grant cycle (such as those due to the complex reporting procedures), WHO’s efforts have had a positive impact and are greatly appreciated by Member States.

44. The existing memoranda of understanding (MoUs) between WHO country offices and the Global Fund Principal Recipients in countries were reviewed. Following this review, the Regional Office organized a meeting with WHO Representatives (WRs) to review the findings and propose guidelines for future WHO collaboration and support at country level in the context of Global Fund-related activities. These guidelines, together with the standard template for MoUs to engage with the GF Principal Recipients, were disseminated to all WHO country offices.

45. The increase in funding to countries also resulted in a substantial increase in country requests for technical assistance to the WHO Regional Office and country offices (COs). Ten countries with continuing GF grants were assisted by WHO/SEARO and COs. Specific support for implementation of Global Fund grants was provided to Bangladesh, Indonesia, Nepal and Timor-Leste through agreements signed with the principal recipients. HIV, TB and Malaria units are working closely with Department of Health Systems Development to assist countries in developing health systems strengthening frameworks, plans and interventions.

46. Up to this point, the generation of financial resources for WHO support has been ad hoc and largely through WHO’s own budget. In order to meet the growing technical assistance requirements there is a need to secure and manage both funding and staffing at the Regional Office and country offices to keep pace with the demand as well as to network more effectively with other partners supporting similar efforts in countries of the Region.

47. Plans for strengthening collaboration between WHO and the Global Fund were also made. A communication focal person has been assigned at SEARO. Four informal consultations with the Global Fund Asia staff to discuss regional collaboration with the fund had been conducted.
A joint plan for operations and coordination of work in countries was drafted in May 2009. Staff from both the Regional Office and country offices exchanged information on a regular basis with Global Fund focal points. GF staff were invited to participate in joint missions conducted for TB programmes in Bhutan, India, Indonesia, Sri Lanka, Timor-Leste; and for the Malaria programmes in Bhutan and Nepal.

**Dengue**

48. There has been an increase in the number of reported cases of dengue in the South-East Asia Region, but better case management has led to a decrease in reported deaths. An increasing incidence of cases has been reported from Indonesia, Myanmar, Sri Lanka and Thailand.

49. The disease incidence rate per 100 000 population has also shown an increasing trend since 2006. Thailand reported an increase in incidence from 74 in 2006 to 121 in 2008. Myanmar reported an increase from 19 in 2006 to 26 in 2008. Indonesia and Sri Lanka reported outbreaks in 2009. The outbreak in Sri Lanka began in April 2009 and around 35 007 cases and 142 deaths were reported, registering a case-fatality rate of 0.40%. Maldives reported 311 cases with no deaths till May 2009. In 2009, India reported 14 381 cases and 81 deaths (case-fatality rate of 0.54%).

Dengue and chikungunya share common control strategies.
Communicable diseases

Figure 1.7: Trend in dengue cases and deaths as reported by Member States of the SEA Region from 2003 to 2008

Source: Country reports, 2009

50. The Asia-Pacific Dengue Strategic Plan 2008–2015 was developed and endorsed by programme managers of both the Western Pacific and South-East Asia Regions.

51. Revision and updating of the comprehensive Guidelines on the Prevention and Control of Dengue and Dengue Haemorrhagic Fever was begun, and peer review of the guidelines was completed in preparation for the publication of the second edition.

Box 1.4: Vector control

A framework for implementing integrated vector management (IVM) at the district level in the Region (step-by-step approach) was developed by the Regional Office in 2008. The course curriculum for training and capacity-building for implementing IVM was also finalized in 2009. IVM has been included in the Regional Malaria Control Strategy. Sri Lanka has demonstrated the successful implementation of IVM, and Indonesia has conducted workshops on implementing IVM. A guideline for sound public health pesticide management (as a part of IVM implementation) was drafted in 2009.

Though the use of long-lasting insecticidal nets (LLINs) has been scaled up over the last few years, its coverage in the Region is still very low. In 2008, the cumulative availability of usable nets (all types, i.e. LLIN and insecticide-treated nets) was around 27.72 million.
Zoonoses

52. Zoonoses risk assessment has been completed in Bhutan, Nepal and Maldives. Both the ministries of health and agriculture of Maldives have provided technical inputs for assessment and a national workshop was organized in Male to disseminate the results of risk assessment. A National Strategy for Zoonoses Prevention and Control was developed accordingly. Bhutan is going to develop a national strategy for zoonoses control based on risk assessment and country needs.

53. All Member States of the South-East Asia Region have established avian influenza coordination committees in the wake of the AI outbreak. WHO has consistently encouraged Member States to reorganize their existing AI coordination committees to accommodate all forms of zoonoses. Indonesia established the National Zoonoses Commission by reorganizing the AI Coordination Committee, and Myanmar is in the process of reorganizing intersectoral coordination mechanisms to cover all zoonoses using WHO guidelines.

54. WHO, the Food and Agriculture Organization of the United Nations (FAO) and World Organization for Animal Health (OIE) had jointly organized an international scientific meeting on Henipavirus in Brisbane, Australia, in October 2009 for which participation of human health and animal health experts from Bangladesh, India, Indonesia and Thailand was sponsored. The meeting acknowledged that the epidemiology of these emerging diseases is not fully understood and recommended capacity-building for outbreak investigation, prevention and control of Henipavirus transmission.

55. The European Commission (EC) and WHO signed an agreement on 10 December 2009 to implement a regional project to strengthen surveillance and response capacity for highly pathogenic emerging diseases. The European Commission is providing four million Euros for the implementation of the project for a period of four years beginning from 2010. The WHO Regional Offices for South-East Asia and Western Pacific will support the Association of South East Asian Nations (ASEAN) and South Asian Association for Regional Cooperation (SAARC) secretariats and Member States to strengthen regional and country capacities to respond to zoonoses. This project was formulated on the basis of the Regional Strategic Framework for Prevention and Control of Zoonoses in the South-East Asia Region developed by WHO-SEARO and recommendations of the Regional Meeting on Zoonotic Diseases organized by WHO-SEARO in Jakarta, Indonesia, in November 2007, and the WHO EC Project; it will contribute to promoting a coordinated
multidisciplinary approach for zoonoses control at the regional and country levels.

56. Rabies and leptospirosis have been identified as priority zoonotic diseases of public health importance in countries of the SEA Region. WHO-SEARO supported Bhutan, Nepal, India, Indonesia and Sri Lanka for capacity-building, mass dog vaccinations, supply of rabies vaccines, and the provision of diagnostic kits for rabies diagnosis. WHO-SEARO organized intercountry hands-on training on laboratory diagnosis of rabies in Bangalore, India on 13-16 April 2009. Experts from CDC Atlanta and three WHO collaborating centres on rabies were invited as resource persons for the training in which medical and veterinary laboratory professionals working for rabies diagnosis from eight rabies-endemic countries participated. WHO-SEARO hosted an informal expert consultation on surveillance, diagnosis and risk reduction of leptospirosis in the SEA Region in Chennai in September 2009. This consultation recommended sensitive case definition, estimation of the disease burden, establishment of leptospirosis surveillance in human and animal populations, strengthening of standard laboratory diagnostic services, and the development of appropriate technology for risk reduction. Technical support has been provided by WHO-SEARO to strengthen standard laboratory diagnostic services through training and the supply of diagnostic kits and equipment for the establishment of the National Leptospirosis Reference Laboratory in Colombo, Sri Lanka.

57. Zoonoses research priorities in the Region have also been identified and research and academic institutions are being encouraged to submit proposals for multidisciplinary operational research.
Neglected tropical diseases

58. NTDs are a major public health problem in the Region and affect primarily the poorest of the poor in the most marginalized sections of society. The Region has over the past few years targeted a select group of four NTDs, i.e. leprosy, lymphatic filariasis, visceral leishmaniasis (kala-azar), and yaws, for elimination or eradication. This would contribute significantly to the achievement of the MDGs.

Leprosy

59. All of the 11 Member States of the Region (except Timor-Leste) achieved the goal of elimination of leprosy as a public health problem\(^1\) by the end of December 2009, as shown in Figure 1.8. On 19 December 2009, the Honourable Minister of Health and Population, Government of Nepal declared “achievement of elimination of leprosy as a public health problem in Nepal”.

60. At the end of 2008, in Timor-Leste, there were 144 cases on multidrug therapy (MDT) treatment and the prevalence rate (PR) was 1.4 per 10 000 population. Concerted efforts were made by Timor-Leste during the biennium toward achieving the goal of leprosy elimination.

\(^{1}\) Elimination of leprosy as a public health problem is defined as a prevalence rate (PR) of below one case per 10 000 population.
61. The South-East Asia Region achieved the goal of elimination at the end of December 2005 with a regional prevalence rate (PR) of 0.87 per 10 000 population. The regional PR was further reduced to 0.69 per 10 000 population, with a total of 120 689 cases on treatment at the beginning of 2009. The total number of new cases detected annually fell from 171 576 cases at the beginning of 2007 to 167 505 cases at the beginning of 2009 (the latest data available for all Member States of the SEA Region). All Member States have adopted and updated their respective national strategies in accordance with the WHO Global Leprosy Strategy and Operational Guidelines (2006-2010). These are being implemented in all Member States in the Region which have also integrated leprosy services into the general health services and are taking measures to further strengthen such integration. The public perception and support to leprosy elimination have continued to improve even as the stigma and discrimination attached to leprosy have continued to decline. WHO has ensured the free-of-charge, regular supply of MDT blister packs to all Member States through the courtesy of one of our partners, the Novartis Foundation. Ten of the 11 Member States of the Region participated in the development and finalization of the 2011-2015 Enhanced Leprosy Strategy and Operational Guidelines. The strategy targets the reduction of Grade II disability due to leprosy at the national level during the period 2011-2015.

62. The Regional Office organized a workshop on leprosy programme management for low-endemic countries (Bhutan, Maldives, and
Thailand) and Timor-Leste. The workshop modules were based on WHO’s Global Strategy and its Operational Guidelines, which were developed in collaboration with the Global Leprosy Programme (GLP) and the partners. The workshop contributed to building capacity among Member States and targeted measures needed to sustain basic knowledge and skill in leprosy diagnosis and case management, including rehabilitation, among national programme managers. Selected national programme managers of high leprosy-endemic countries (Bangladesh, Indonesia, Myanmar and Nepal) were invited to share their experiences in sustaining leprosy activities in their respective countries. As a result, some Member States (India, Indonesia, Myanmar and Timor-Leste) conducted and others are planning (Bangladesh, Bhutan and Nepal) in-country workshops in collaboration with partners using the same modules.

In spite of the above achievements, during 2008, 67% of the global total of new cases were detected in the SEA Region. Globally, 17 countries reported 1000 or more new cases during 2008. Of these, six countries were from this Region (Bangladesh: 5249 cases; India: 134 184; Indonesia: 17 441; Myanmar: 3365; Nepal: 4708; and Sri Lanka: 1979).

The SEA Region has two priority countries (India and Indonesia) with large populations that report large numbers of new leprosy cases annually. At the same time, Bangladesh, Myanmar and Sri Lanka, in spite of the large numbers of new cases detected, have achieved and sustained elimination of leprosy at the national level, and are making concerted efforts to further reduce the leprosy burden. However, these three countries have a number of highly endemic pockets. Continued WHO support, including adequate resources, will therefore be crucial to consolidating the gains made and to further reduce the burden of disease.

Global Leprosy Programme

Leprosy is one of the few communicable diseases where the disease burden is declining and the control activities carried out by the national programmes in many endemic countries have played a significant role. The Global Strategy for Further Reducing Leprosy Burden and Sustaining Leprosy Control Activities 2006–2010 has been adapted and implemented in all endemic countries globally. The strategy aims at sustaining the gains already achieved by promoting
integration within the general health-care system and ensuring that new cases are detected at an early stage and promptly treated with multidrug therapy (MDT). This has renewed the focus on quality of services, reaching underserved communities and building effective partnerships to further reduce the disease burden.

66. Globally, the number of new cases detected annually continues to decline, falling by 60% to 249 007 cases in 2008 from 620 638 cases in 2002. The free availability of MDT drugs worldwide has helped cure more than 15 million people affected by leprosy since 1995 and has prevented the occurrence of disabilities among another two to three million persons.

Table 1.1: New case-detection trend between 2002 and 2008 classified by WHO Region

<table>
<thead>
<tr>
<th>WHO Region</th>
<th>Number of new cases detected during the year</th>
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<tbody>
<tr>
<td></td>
<td>2002</td>
</tr>
<tr>
<td>Africa</td>
<td>48 248</td>
</tr>
<tr>
<td>Americas</td>
<td>39 939</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>520 632</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>4 665</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>7 154</td>
</tr>
<tr>
<td>Total</td>
<td>620 638</td>
</tr>
</tbody>
</table>

Note: excludes the European Region.

67. The Global Leprosy Programme effectively carried out its activities in collaboration with other Regions, partners and Member States of the Organization. The Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy 2011-2015 and its Updated Operational Guidelines were developed in collaboration with various stakeholders, and these were endorsed by all partners at the “Global Programme Managers’ Meeting on Leprosy Control Strategy” held in New Delhi, in April 2009.

68. A sentinel surveillance network to monitor drug resistance in leprosy was also set up in eight endemic countries. Capacity-building workshops for programme managers from low-endemic countries were carried out in Bamako, Mali (African Region) Taiz, Yemen (Eastern Mediterranean Region), Shanghai, China (Western Pacific Region) and Dhaka, Bangladesh (South-East Asia Region).
69. The global leprosy situation is being monitored and data from over 120 countries have been compiled and published in the *Weekly Epidemiological Record*.

70. Measures to eliminate stigma and discrimination against persons affected by leprosy are being initiated in endemic countries. Continued efforts are being made to improve collaboration and create greater synergy with national and international partners.

71. The leprosy control programmes in Member States have been successful in their efforts to reduce the disease burden. However, there is no room for complacency and it is important to sustain political commitment in the context of the declining number of new cases and the competing priorities. Maintaining expertise in leprosy among health workers, especially in countries where the disease has become relatively rare, is another issue. Information, education and communication (IEC) efforts to improve awareness and reduce stigma and social discrimination will be augmented.

72. Efforts to reduce the disability burden and develop appropriate tools for the prevention of disabilities and rehabilitation will be further promoted. Research will be promoted to prevent the occurrence of leprosy (e.g. vaccine/chemoprophylaxis) and to develop better and shorter treatment regimens which can be used more effectively in integrated leprosy control programmes.

**Lymphatic filariasis**

73. Nearly 66% of the global estimate of 1.3 billion people at risk for lymphatic filariasis (LF) are in the South-East Asia Region—some 851.3 million people, in nine of the 11 Member States. The disease directly affects 60 million people in the Region with either microfilaraemia or clinical manifestations of lymphatic filariasis, which amounts to 50% of the global burden of the disease. All three parasites responsible for the disease are found in the Region. A Strategic Plan for the Elimination of LF in the SEA Region (2010–2015) was developed.

74. All nine endemic countries in the Region have adopted the WHO-recommended two-drug strategy for mass drug administration (MDA). Mapping of LF has been completed in all endemic countries as well. After six rounds of MDA, Sri Lanka stopped MDA and initiated post-MDA surveillance in 2008. Thailand continued the treatment of the population for the last few remaining endemic foci. In India, after
changing the strategy from diethyl carba-mazine citrate (DEC) single-drug treatment to DEC and albendazole, the number of people treated with combination therapy has been steadily increasing. In 2008, 162 million people were treated with combination therapy compared to 107 million the year before. The number is likely to dramatically increase in 2009–2010 since India is committed to the two-drug regimen in all implementation units (districts).

75. Three countries (Maldives, Sri Lanka and Thailand) have completed more than five rounds of MDA to the entire eligible population and reduced the microfilariaemia (Mf) rate to less than 1%, preparing the way for the certification process for the elimination of lymphatic filariasis (ELF). India (which contributes more than 40% of the global LF burden) brought down the Mf rate to less than 1% in 192 districts. By the end of 2009, there were only 14 districts (out of 51) in Bangladesh where the Mf rate was more than 1%. In four districts of Myanmar, the Mf rate came down from 4.7% (2001) to 0.54% (2008), and in a sentinel survey of 11 districts, the Mf rate was reduced from 4.4% (2002) to 1.05% (2008).

76. Indonesia harbours all the three parasites in many districts on different islands. As recommended by the Sixth Regional Programme Review Group, the Regional Office deputed a mission to the country to hold discussions with the national authorities. Indonesia has strengthened LF elimination activities and is expanding the programme throughout the country.

77. Globally, nearly 2500 million people were covered by mass drug administration by 2008, of which 86% live in the SEA Region. The Region is contributing greatly to the success of the global LF elimination programme. The speedy progress towards successful implementation of MDA is very encouraging and the Region is heading towards achieving the goal of elimination earlier than the targeted year of 2020.

**Soil-transmitted helminths (STH)**

78. Soil-transmitted helminths (STH), commonly known as intestinal worms, are one of the most common infections worldwide and often affect the most deprived members of the population. The common soil-transmitted human helminths in the Region are roundworms,
whipworms and hookworms. Ten of the 11 Member States have national deworming policies.

79. The Region contributes 38% of the total preschool-age and 41% of total school-age children at risk globally. Since STH are endemic in all 11 Member States, a national focal point has been appointed by the ministry of health in all countries for STH programme implementation. Bhutan, Maldives and Sri Lanka are targeting the entire high-risk school-age population. DPR Korea reported a 40% STH burden among school-going children in 2009. Among children in Indonesia it varied from 0.5% (Central Java) to 57% (Maluku) during 2009.

80. The Region has made substantial progress towards the elimination and eradication of the targeted diseases. However, important challenges need to be addressed. Sustaining political commitment and providing adequate resources are of the utmost importance. Ensuring the uninterrupted supply of drugs and a wider coverage of health services, especially for currently underserved population groups, is also vital. Member States are collaborating and learning from each others’ experience. Intersectoral coordination forged by the health sector will be essential to tackle cross-cutting issues. Strengthening the integration of specific national disease control programmes into the health systems remains important.
Kala-azar elimination

81. Kala-azar affects the poorest of the poor and is endemic in 109 districts, in Bangladesh (45), India (52) and Nepal (12). If left untreated, the disease can be fatal. Because of its unique epidemiology (humans are the only reservoir, confined to limited areas in the three countries), the availability of an effective treatment and rapid diagnostic test (rK39), the effectiveness of indoor residual spraying (IRS) for vector control, and with strong political commitment, it is possible to eliminate the disease from the Region. A Memorandum of Understanding (MoU) was signed by health ministers of Bangladesh, India and Nepal in 2005 in Geneva to collaborate with each other, and to eliminate the disease by 2015 by achieving the target of less than 1 case per 10 000 population in affected areas.

82. Anti-leishmaniasis medication (oral miltefosine), rapid diagnostic tests (rK39) and indoor residual spraying (IRS) for vector control are now being utilized in the three countries. The kala-azar elimination programme was started in eight districts in India, one district in Bangladesh, and two districts in Nepal. It is now being expanded to all districts in India, 10 districts in Bangladesh and 12 districts in Nepal. Meetings of programme managers and high-level officials were held in the Regional Office in February 2009. The Regional Office and WHO headquarters jointly carried out advocacy meetings with health ministers and other high officials of the three countries.

83. The three kala-azar-endemic countries need to urgently increase budgetary allocation to fund their elimination programmes. Donor agencies like the World Bank and JICA are helping Bangladesh and India; they should extend the same help to Nepal. Adequate supply of good quality miltefosine and diagnostic test (rK39) should be available in the three countries. Furthermore, surveillance, information, education and communication (IEC) and cross-border collaboration need to be strengthened.

Research

84. In 2004, the Regional Office took the initiative to support tropical diseases research through the Small Grants Programme to train young scientists from Member States; 58 proposals received from Member States of the Region were funded up to 2009.
Table 1.2: WHO-Tropical Diseases Research (TDR) Small Grants Programme-supported projects from 2004–2009

<table>
<thead>
<tr>
<th>Year</th>
<th>TDR contribution (US $)</th>
<th>Number of proposals received</th>
<th>Number of proposals sent to Research Review Committee</th>
<th>Number of proposals funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>50 000</td>
<td>9</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>2005</td>
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<td>10</td>
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<tr>
<td>2008</td>
<td>50 000</td>
<td>58</td>
<td>26</td>
<td>13**</td>
</tr>
<tr>
<td>2009</td>
<td>75 000</td>
<td>36</td>
<td>22</td>
<td>11</td>
</tr>
</tbody>
</table>

**6 funded from TDR and 7 from CDS pool fund.

85. Other research initiatives were also undertaken by the Regional Office. Meetings were organized in March 2009 to identify research priorities for the Region, as well as the appropriate research methodology, and to discuss proposal writing for research grants.

86. Research results are often not used in disease control programmes, and the Regional Office is playing an increasing role in translating research into policy. Research is also being directed toward the important issue of the impact of climate change on human health. Generic protocols have been prepared and are being used by two countries (India and Nepal) for retrospective studies on the impact of climate change on diarrhoeal and vector-borne diseases.

Yaws

87. Until recently, yaws was endemic in three countries of the Region: India, Indonesia and Timor-Leste. India declared elimination in 2006, and with no cases reported after that, the country is heading towards eradication of yaws. The disease is now reported from only 14 of the 33 provinces of Indonesia and six of 13 districts in Timor-Leste. WHO is continuing to provide technical support to affected Member States to scale up the yaws elimination programme.

88. In 2009, 7,751 cases of yaws were reported in Indonesia, nearly 50% of them among children. More than 90% of the reported cases were from Nusa Tenagara Timur (NTT) province. An estimated 1000 cases occur in Timor-Leste.
89. Due to active case finding, more cases and their contacts are being detected and treated in Indonesia under the Yaws Elimination Programme.

**Blood safety and clinical technology**

**Laboratory services: responding to influenza pandemic and emerging infectious diseases**

90. The capacity of all countries to diagnose novel pandemic virus was strengthened by upgrading the skills of laboratory professionals concerned to perform and interpret PCR-based processing. The quality of testing was assessed through the external quality assessment scheme and showed excellent results. National laboratories in Bangladesh, Myanmar and Nepal were designated as National Influenza Centres (NIC), thus making them members of the Global Influenza Surveillance Network (GISN).

91. Critical influenza diagnostic reagents that are not commercially available were supplied to all national laboratories. On-site training was organized for Maldives that resulted in establishment of a PCR facility for the first time in that country. National networks of influenza laboratories were supported in India, Indonesia and Thailand.
The laboratory component of national response to the influenza pandemic was reviewed in Thailand with the objective of improving efficacy of the health system in combating such emergencies. Efforts were initiated to build national PCR-based diagnostic capacity in Bhutan and Timor-Leste. Steps were initiated to develop capacity for determining drug resistance in influenza viruses in laboratories in the Region.

Networks of laboratories for emerging pathogens have been developed that aim to build regional diagnostic capacity for plague, Nipah, dengue fever, acute diarrhoeal diseases, zoonoses, pneumonias and neurological infections. Member institutions, mechanism and protocols for these networks have been agreed upon by participants.

Laboratory biosafety and biosecurity have emerged as an important component in the war against dangerous pathogens. A regional workshop was organized to disseminate the essential principles and practices, and Bhutan, India and Nepal were provided technical support to enhance the biosafety and biosecurity of their laboratories.

In collaboration with the WHO Regional Office for the Western Pacific, the Asia-Pacific Strategy for Strengthening Health Laboratories (APSLab) was finalized after extensive consultations. Nepal has already begun to use the APSLab in developing national policy and plans for health laboratories. Regional documents on strengthening quality, initiating accreditation and implementing quality systems in health laboratories were widely disseminated, and guidelines for establishing a virology laboratory are being utilized by countries.

### Box 1.5: Key strategic elements for health laboratory services

- Establish a coherent national framework for laboratory services.
- Finance laboratory services in a sustainable manner.
- Build capacity for laboratory services.
- Ensure the quality of laboratory services.
- Promote the rational use of laboratory services.
- Maintain safe laboratory services.
- Support research and ethics in laboratory services.
- Improve laboratory support for HIV diagnosis and antiretroviral therapy.
Communicable diseases

96. The external quality assessment scheme to monitor the quality of CD4 enumeration in 161 laboratories revealed continuous improvement in their performance with the coefficient of variation decreasing to 5% from 15% during the period under review. Regional guidelines on HIV diagnosis and monitoring of antiretroviral therapy (ART), as well as guidelines on enumeration of CD4 T Lymphocytes in the context of HIV/AIDS were revised, published and disseminated. Recognizing that diagnosis of fungal opportunistic infections in people with HIV requires strengthening in the Region, a WHO collaborating centre (CC) on this subject was designated. This WHO CC also facilitated the drafting and finalization of a manual on laboratory diagnosis of fungal opportunistic infections.

Improving access, quality and safety of blood

97. The WHO Global Strategy on Safe Blood has been adopted by all Member States. National blood policies were formulated in Bhutan and Maldives, while Nepal and Thailand initiated the process of revision of their existing national blood policies to incorporate the advances made in transfusion sciences. Myanmar drafted a blood policy through national consensus.

98. The strengthening of the National Blood Centre in DPR Korea has aided provision of quality blood collection and screening services and
conversion of blood into blood components. WHO provided support to Bhutan, DPR Korea and Maldives to improve the quality of their blood collection and screening services. Nepal received support to develop a national strategic plan, as well as to provide access to safe blood to pregnant women in peripheral health units. The Regional External Quality Assessment Scheme for blood grouping and screening of HIV antibodies was implemented in seven countries and demonstrated improvement in the quality of results.

99. To build managerial capacity of national blood transfusion programme managers, two biregional workshops were organized in collaboration with the Government of Singapore at the WHO Collaborating Centre, Singapore. Biregional workshops were also held to improve the quality of screening of blood for infectious markers and strengthening of national blood programmes. The WHO Collaborating Centre on Training in Blood Transfusion in Bangkok, was redesignated, and continues to act as a resource centre for the entire Region.

100. Recognizing the serious public health implications of the emerging problem of antimicrobial resistance, a Regional Strategy for Prevention and Containment of Antimicrobial Resistance was developed through an extensive consultative process in the Region. The strategy has been shared with all Member States. A number of key challenges remain, such as enhancing regional self-reliance in diagnosis of emerging infectious diseases; preventing and containing antimicrobial resistance in pathogens of public health importance; and improving voluntary non-remunerated blood donations and ensuring the quality of screened blood to mitigate transmission of HIV, hepatitis B and C and other blood-borne pathogens.
Noncommunicable diseases and social determinants of health

Noncommunicable diseases (NCDs)

1. Noncommunicable diseases (NCDs) of chronic character such as cardiovascular disease, diabetes, cancers and chronic lung diseases account for an estimated 54% of the 14.7 million annual deaths and nearly half of the total disease burden occurring in the South-East Asia Region. This increasing burden of NCDs is the outcome of three main processes: ongoing demographic change, unhealthy behaviours by growing segments of socioeconomically disadvantaged urban and rural dwellers, and the failure of health systems to protect the health of the people and deliver basic health services in an equitable way.
2. Contrary to long-held beliefs, the poor are now extensively and disproportionately exposed to the health-harming impacts of man-made socioeconomic, psychosocial, cultural, political and physical environments. Tobacco use, harmful use of alcohol, inadequate consumption of fruits and vegetables and preferential use of less expensive foods rich in saturated and partially hydrogenated fats and salt have become increasingly common among the disadvantaged, vulnerable and marginalized. Effective, efficient, workable, low-cost public health solutions to the NCD problem in developing countries are known, but largely underutilized.

3. The major focus of WHO efforts with regard to NCDs during the biennium was to assist Member States in strengthening their national capacity for formulation, implementation and evaluation of policies, plans and programmes for the integrated prevention and control of NCDs. The SEA regional package of NCD capacity-strengthening materials was revised, updated and expanded, and extensively used at national workshops conducted with WHO assistance in Bangladesh, DPR Korea, Myanmar and Sri Lanka. The Regional Office also developed a comprehensive set of materials to train managers and facilitators of national and subnational NCD capacity-strengthening programmes. WHO also mounted a training for NCD programme workforce from nine Member States on planning and conducting national NCD capacity-strengthening activities.

NCDs can be combatted with low-cost public health solutions.
4. Direct technical assistance was provided to Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal and Sri Lanka in formulating, implementing and evaluating national NCD policies, action plans and programmes. Bhutan and Sri Lanka were supported in implementing evidence-based interventions for the prevention and control of NCDs at the primary care level; a WHO package of essential NCD interventions (PEN) was introduced at training workshops. Subsequently, the feasibility of a broad application of the package was pilot-tested in select districts of both countries. Community-based intervention projects were supported in India, Indonesia and Thailand.

5. NCD risk factor surveys in Bangladesh, Bhutan, DPR Korea, India, Maldives, Myanmar and Nepal were supported at various stages, including planning, implementation, data analysis and results dissemination. A set of indicators for reporting core NCD mortality, morbidity and risk factors data was developed.

6. The Regional Office continued to provide secretariat support to strengthen and promote the SEA Network—SEANET-NCD—focusing on partnership building and capacity strengthening for resource mobilization. Two institutions involved in NCD control joined the network of regional WHO collaborating centres, and the process of designating three other centres was advanced.

7. To address oral diseases, a regional consultation was organized in 2008 to discuss the challenges in oral health promotion and integrated disease prevention. The strategies worked out at this meeting were used in strengthening national oral health policies and programmes in the Region.

8. NCDs present a growing health and economic challenge to the Region. There is mounting evidence on the progressive socioeconomic divide in terms of exposure to NCD-causing factors and access to basic health services by people at risk and those with established NCDs. Efforts are needed to develop and implement workable, low-cost solutions to the NCD problem and to recognize the urgent need to invest in prevention and control measures. The persistent gap in allocation of human and financial resources needs to be bridged, and the capacity of the health workforce and partners outside the health sector to implement public health-oriented NCD prevention needs to be increased.
Mental health and substance abuse

9. Activities during the biennium in this area have focused on four issues:

(1) Strengthening the existing primary care system in Member States to deliver essential mental health care;
(2) promotion of mental well-being in the community;
(3) reducing harm from alcohol use in the community; and
(4) a cluster of other projects, including adolescent mental health, suicide prevention, reducing harm from psychoactive substance use, addressing learning and behavioural disorders among children, community-based rehabilitation of the intellectually impaired, and psychosocial and mental health needs of disaster-affected communities.

10. The Regional Office has developed a strategy to deliver essential mental health care to all persons, including those in rural and remote areas, who need such care. The optimum method of delivering such care is strengthening the existing primary care system. In order to do this, village-based health workers are being trained to identify the most common and disabling neuropsychiatric conditions. Based on information from community-based studies in Member States, epilepsy, psychosis and depression are the most common and disabling conditions. Materials have been developed to train community-based health workers to identify these conditions, and train community-based general physicians to treat them using approved medications. The publications are Training Manual for Community-Based Health Workers on Identification and Care of Generalized Tonic-Clonic Seizures (Major Fits); Training Manual for Community-Based Physicians on Treatment of Generalized Tonic-Clonic Seizures (Major Fits) (using Phenobarbital).

This strategy has been successfully applied for epilepsy in Maldives, Myanmar, Nepal and select states of India. The programme has reduced the treatment gap from 95 per cent to less than 10 per cent.

11. The concept of promotion of mental well-being is based on “primordial prevention”, which attempts to prevent the occurrence of risk factors in the community. Instead of treating the consequences of stress through counseling or medication, it is more beneficial to prevent its occurrence in the first place. Traditional practices used in Member States (for example Bhutan, India, Myanmar, Nepal, Sri Lanka and
Thailand) for centuries are being promoted, such as yoga, meditation and Vipasana. An intersectoral workshop on the promotion of mental well-being was conducted in Colombo, Sri Lanka, in October 2009. Delegates discussed community-based programmes and advocated that existing programmes be evaluated for their impact.

12. Harm from alcohol use is a major concern in several countries and is linked to rapidly increasing consumption of alcohol, particularly in urban slums and rural and remote areas. Of particular concern is the use of home-brewed and illicit alcohol and country liquor. Alcohol is inextricably linked to poverty and gender-based violence. All Member States have contributed to the WHO document “Strategies to Reduce the Harmful Use of Alcohol: Draft Global Strategy”. The draft strategy covers 10 policy options; of particular importance are community action and reducing the public health impact of illicit and informally produced alcohol. Community action is the best method of controlling harm from alcohol, particularly from illicit and informally produced alcohol, which is widely available in the Region. Pricing and control of availability can also help. Community action to reduce harm from alcohol is being tested in India, Sri Lanka and Thailand.

13. To address adolescent mental health, the life-skills approach is being used in Bhutan, India, Indonesia, Myanmar, Sri Lanka and Thailand. Suicide prevention is being addressed through safe storage of pesticides (Sri Lanka, and Tamil Nadu in India). The Regional Office is also addressing learning and behavioural disorders among children through advocacy programmes in all countries of the Region. Community-based rehabilitation of the intellectually impaired (India, Indonesia and Maldives); and the psychosocial and mental health needs of disaster-affected communities (all Member States) have also been supported.

14. Challenges remain in this area, such as scaling up programmes and strengthening the health system to deliver essential mental health care by training community-based health workers, as well as through advocacy with governments. The concept of promotion of mental well-being needs to be developed as a public health strategy through the testing of community-based projects and assessment of their impact and benefit for the community. Further testing of programmes on reducing harm from alcohol use in the community also needs to be done, with the adaptation and scaling up of successful models.
Tobacco free initiative (TFI)

15. Tobacco use kills over 1.2 million people annually in South-East Asia. Control of the tobacco epidemic in the Region is complex due to widespread availability and use of smokeless and other cheaper indigenous smoking tobacco products such as bidi and cheroots, and the inequality of taxation on different tobacco products. Although five countries in the Region have comprehensive tobacco control legislation in place, and other countries are in the process of developing the same, inadequate enforcement of tobacco control measures has been a general problem in the Region.

16. Efforts have been made to implement the MPOWER policy package as well as the guidelines developed by the Conference of Parties for effective implementation of the WHO Framework Convention on Tobacco Control (FCTC). Tobacco control efforts are also being supported mainly in four Bloomberg Initiative (BI) focus countries in the Region. The knowledge and skills of national counterparts have been enhanced through intercountry and national awareness building and training workshops. Countries of the Region have been supported in strengthening tobacco control legislation through intercountry workshops, enhancing the capacity for drafting and amending legislation.
17. The Regional Office has made sustained efforts to link the impact of tobacco control on poverty alleviation and the achievement of MDGs through consultative meetings of UN agencies and partners. Policy-makers and legislators were briefed about the economic benefits of tobacco control, and tobacco tax assessments were completed in two countries. Intercountry workshops have been held on the protocol on illicit trade in tobacco products to enable Member States to participate in negotiations on the protocol. A national capacity assessment on tobacco control was conducted in Thailand. Advocacy was conducted through the publication of tobacco control profiles for Myanmar and Sri Lanka and a Regional Communication Strategy and other advocacy documents to advance implementation of the FCTC.

18. A large-scale advocacy campaign based on the 2008 theme of World No Tobacco Day (WNTD) (“Tobacco-free Youth”) and the 2009 theme (“Tobacco health warnings”) was undertaken. As part of these campaigns, a number of documents and factsheets were produced and disseminated among countries and stakeholders, both as advocacy tools and to guide countries in revising and strengthening their tobacco control programmes.

19. The Regional Office also made efforts to promote multisectoral collaboration within countries. Bangladesh, India, Myanmar and Thailand have incorporated tobacco control into the school curriculum in collaboration with their ministries of education. South-East Asia is the first among the WHO regions to initiate collaboration with the TB control programme by integrating the PAL (Practical Approach to Lung Diseases) approach in the TB control programme, including the completion of a pilot project on TB and tobacco in Nepal. Two other Member States were also supported in this area.

20. Significant progress was achieved in the area of tobacco surveillance. All components of the tobacco surveillance system were implemented in the Region. The South-East Asia Region is the only one that completed and released the Report of the Global Adult Tobacco Survey (GATS) in Bangladesh and Thailand under the Bloomberg Initiative.
Figure 2.1: Key findings of GATS in Bangladesh and Thailand in terms of MPOWER indicators, 2009

Source: Global Adult Tobacco Surveys (2009), Bangladesh and Thailand.

MPOWER Policy Package

- Monitor tobacco use and prevention policies
- Protect people from tobacco smoke
- Offer help to quit tobacco use
- Warn about the dangers of tobacco
- Enforce bans on tobacco advertising, promotion and sponsorship
- Raise taxes on tobacco

21. These surveys helped Member States to assess trends in the tobacco epidemic and to revise policies and programmes, as well as to meet obligations under certain specific provisions of the FCTC. The Regional Office also initiated an integrated surveillance approach to tobacco surveillance through STEPS (WHO STEPwise approach to noncommunicable disease risk factor surveillance). This approach has already been adopted in Myanmar and Nepal. To support tobacco cessation services in the Region, a cessation manual for doctors, dentists and nurses was developed, and a Regional Tobacco Cessation Training Workshop for training of trainers was organized in which 9 Member States participated.

22. While enforcement of existing tobacco control measures will continue to be an important issue, strengthening tobacco control legislation and
existing measures in line with the Framework Convention also poses a challenge for the Region. In addition, serious efforts and advocacy will be required to ratify the protocol on illicit trade in tobacco products. It will be important to integrate tobacco surveillance with surveillance of other risk factors and to make it part of the health information system, in order to avoid duplication of efforts and resources.

**Disability, injury prevention and rehabilitation**

23. The SEA Regional Office has advocated with and supported countries to increase political, financial and technical commitment on injury prevention and building of institutional capacity. An injury prevention cell has been established in the Ministry of Health, Maldives, which brings the total number of Member States in the Region having an injury unit in their MoH to four including Indonesia, Sri Lanka and Thailand.

24. An Intercountry Workshop for Trainers on Injury Epidemiology, Prevention and Care was organized in Khon Kaen, Thailand in 2008; subsequently, such training was carried out at the national level in Thailand and also India, and injury prevention and care activities in several other countries received impetus. A second initiative, an Intercountry Workshop for Injury Surveillance System conducted...
in Bandos, Maldives in 2009, aimed to strengthen country capacity in generating injury surveillance reports and disseminating the information across sectors. Bhutan, India, Myanmar, Nepal and Sri Lanka have piloted the injury surveillance system. Injury surveillance reports of Thailand were translated for sharing with the international public health community.

25. Member States, together with the Regional Office, developed the Status Report on Road Safety to identify both the gaps and the key priorities for intervention, as well as to stimulate road safety activity at the national level. During the biennium, the National Road Traffic Safety Policy and Strategy was endorsed in Bangladesh and Maldives.

26. The Profile of Child Injuries in Selected Member States of the Asia-Pacific Region was produced, as well as a fact sheet on child injury prevention in the Region. Drowning among children has become a priority agenda item in Thailand, and the intervention programme has been expanded for the entire nation.

27. Special briefing seminars and conferences were organized to raise awareness of the Convention on the Rights of People with Disabilities. An information booklet for policy-makers on the roles and responsibilities of the health sector with regard to the Convention—the first of its kind globally—was developed. A disability access audit was conducted at the Regional Office premises and the recommendations approved for action. Staff recruitment policies and the WHO-SEARO website are being made more accessible for persons with disabilities. To ensure coordination and inclusiveness of people in WHO technical programmes, disability mapping was conducted.

28. The First Asia-Pacific Congress on Community-based Rehabilitation (CBR) was organized in 2009 by the WHO Regional Office, WHO headquarters, the Asia-Pacific Development Centre on Disability (APCD), the Government of Thailand and several international agencies to highlight the evidence of innovative activities and the need for research in CBR. Many people with disabilities also attended the congress and made presentations.

### Blindness and deafness

29. A comprehensive situation analysis on VISION 2020 of the SEA Region and a framework for developing an action plan for a comprehensive eye health programme for blindness prevention was developed. Bangladesh, Myanmar and Nepal were supported in implementing national blindness prevention. India has been supported
in developing information, education and communication (IEC) materials on ocular emergency and diabetic retinopathy. Thailand has an established multisectoral partnership structure for blindness prevention. Technical coordination and support to assess the blindness situation and information, including strengthening of the National Blindness Prevention Committee, has been initiated and is currently ongoing.

30. A draft Five-Year Plan for the Prevention of Deafness and Alleviation of Hearing Impairment for the SEA Region 2010-2014 has been developed in collaboration with the Sound Hearing Society. Assessment of the epidemiology of hearing loss in all Member States and a regional symposium on “infant hearing screening” was conducted in 2009. India was supported in human resources development and in implementation of the model for the school programme to prevent deafness and alleviate hearing loss.

31. Injury and disability prevention and rehabilitation share similar challenges, such as limited information, budget and human resources, especially in epidemiology and primary prevention. Development of multisectoral collaboration and a strategic approach to problem-solving and resource mobilization are crucial.

Health promotion and education

32. Health promotion and education (HPE) in the Region are carried out mainly through policy advocacy and multisectoral training. Capacity-building initiatives for health promotion and education require the

Sustainable health promotion mechanisms are being implemented in the Region.
involvement of both health and non-health professions, as well as strengthening of infrastructure. The role of local academic institutions is critical to health promotion and education.

33. HPE activities implemented in countries of the SEA Region during the reporting period focused on strengthening health promotion practice, building capacity and formulating multisectoral and multidisciplinary task forces, mainstreaming health promotion in national policies and activities, and establishing sustainable mechanisms for implementation of health promotion. The Regional Strategy for Health Promotion for South-East Asia was developed and published to provide a strategic guideline and framework for countries to build a critical mass of human resources for health promotion, drawn from health and non-health disciplines.

34. Training of health and non-health professionals in health promotion practices was conducted in Bhutan, India and Timor-Leste. SEARO developed two training packages and organized trainings of trainers for community health workers, school health coordinators, academics and staff of related ministries in the three countries. HPE provided the training through partnerships with academic institutions, namely the National Institute of Public and Social Medicine, Bangladesh; the Royal Institute of Health Science, Bhutan; the National Institute of Health and Family Welfare, India; and the Institute of Health Sciences, Timor-Leste.

School health promotion is a key aspect of the regional health promotion strategy.
35. School health promotion is a key aspect of the regional strategy using a setting-based approach. Global School Health Survey (GSHS) training, data collection, analysis and reporting were supported in India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand. The GSHS results provided important evidence for formulating strategic planning and interventions for implementation of the school health promotion programme. Through a series of workshops, three further guidelines were developed: *Guidelines for Oral Health Promotion in Schools, Guidelines for Water, Sanitation and Hygiene in Schools, and Guidelines for Monitoring and Evaluation of the School Health Promotion Programme*.

36. Technical support was provided to Bangladesh, India, Maldives and Sri Lanka to develop national health promotion policies. Intercountry consultations on health promotion financing and addressing equity gaps were organized. A five-country study on the status of health promotion financing and innovative financing was conducted in India, Indonesia, Nepal, Sri Lanka and Thailand. A regional consultation on options for financing health promotion in 2009 reviewed the study findings and provided strategic directions in this area for the Region. Health equity analysis was conducted in six countries using Demographic and Health Survey (DHS) data, and the impact of social determinants on health outcomes was identified.

37. The Regional Consultation on Social Determinants of Health: Addressing Health Inequities held in Colombo led to the “Colombo Call for Action”, which recognized the existence of inequities in health in SEA Region countries and provided guidance on tackling them through political commitment—putting “closing the gap in a generation” on the national agenda and mainstreaming health equity in all policies.

38. Regional strategies will need to be brought in line with the “Nairobi Call to Action for Closing the Implementation Gap in Health Promotion”, adopted in 2009. The strengthening of health promotion practices and skills in countries of the Region will need continued support, and could be facilitated by the establishment of an SEA Region Social Science Network on Social Determinants of Health. Monitoring and evaluation of health promotion activities across issues, population groups and settings is also a continuing need.
Primary and community health care

1. In response to the regional consensus to revitalize primary health care, the Primary and Community Health Care Unit was created in the Regional Office in June 2009. The Regional Conference on Revitalizing Primary Health Care held in Jakarta, Indonesia in August 2008 had called for adopting a “development approach” to strengthening health systems. The Regional Office for South-East Asia subsequently supported the development of a Strategic
Route Map (SRM) in Thailand. The SRM is a management tool to empower the community in health development. The WHO Regional Office for the Eastern Mediterranean (EMRO) has shown interest in applying SRM and has planned to visit Thailand for this purpose. Senior officials from Bangladesh, India, Indonesia, Sri Lanka and Thailand were oriented to SRM through a multicountry activity organized in Bangkok in May 2009.

2. To strengthen intercountry collaboration, a team from Thailand visited Sri Lanka to observe PHC innovations/initiatives in that country.

3. Community-based initiatives (CBI) are an important element of primary health care. Several countries in the Eastern Mediterranean Region have established effective models of CBI. To promote similar initiatives in the South-East Asia Region, a knowledge exchange programme of high-level officials from Bangladesh, India, Indonesia, Sri Lanka and Thailand was organized in Morocco in November 2009. Participants interacted not only with Moroccon policy-makers and programme managers, but also with community-based workers and volunteers and community members as well. This visit will be followed by a reciprocal visit by EMRO to Thailand to observe SRM.

4. Bangladesh embarked upon an ambitious countrywide project to strengthen and expand community-based health services through Community Health Clinics. In support of this initiative the Regional
Office arranged an observational field visit of a team of senior officials from Bangladesh led by the Adviser to the Prime Minister to study similar initiatives in India and Myanmar. The Regional Office is providing technical support for the project and also provided ambulances to three districts to strengthen referral transport under the project.

5. To provide a regional platform for ideas exchange on PHC, the Regional Office, in consultation with Member States, established the PHC Innovations Network. This network will draw its membership from grassroots institutions active in PHC and will serve as a think-tank for revitalizing primary health care in the Region. To promote interregional cooperation, the Regional Office has entered into a collaborative agreement with the Regional Office for the Eastern Mediterranean (EMRO) to facilitate exchange of experiences and build capacity for PHC implementation.

6. Recognizing that PHC is an intersectoral effort, an interdepartmental working group was created in the Regional Office to guide PHC-related activities. The focus of activities is on health policy analysis, promoting self-care by individuals and communities, urban primary health, strengthening referral care and knowledge, family medicine and dissemination regarding regional and global innovations in primary health care.

**Making pregnancy safer and reproductive health**

7. All pregnant women and their newborns have the right to get the best possible health care, especially during childbirth and immediately after, when most complications and deaths occur. One of the indicators for Millennium Development Goal (MDG) 5 is the proportion of births attended by skilled health personnel, with the targets for high MMR countries set at 50% and 60%, by 2010 and 2015 respectively and 85% and 90% globally. Although 4 out of 11 Member States have achieved universal coverage for skilled care at birth, four others have not achieved the 50% target. This lack of access to key maternal and newborn health (MNH) care continues to be the main issue in the Region, besides the issue of overall quality of care.
8. To promote the achievement of “skilled care at every birth”, the Sixty-first Session of the Regional Committee urged Member States to strengthen the database and national plan for human resources for maternal and newborn health, as well as to improve MNH human resource management at entry, performance and exit levels. During the period under review, Member States were supported in strengthening pre-service midwifery training; improving neonatal health through promoting essential newborn care; improving quality of pre-service and in-service midwifery training; and improving quality of MNH services, including adaptation and utilization of evidence-based guidelines and tools. Evidence-based guidelines for MNH were translated and utilized widely. Member States are accepting family planning, skilled care at birth, emergency obstetric care and essential newborn care as the main interventions for reducing maternal and neonatal mortality.

9. Multi-year projects on MNH are being implemented in Bangladesh and DPR Korea with external resources. A multi-year project on newborn health is ongoing in Myanmar. Neonatal health was promoted in nine countries.

10. Various activities to strengthen management of MNH programmes were carried out in Bangladesh, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste. Bangladesh and Timor-Leste worked on strengthening district programme management through the District Team Problem-Solving approach and Local Area Monitoring for MNH, respectively. Indonesia worked on the development of maternity waiting homes for remote areas; Maldives on disseminating Maternal Mortality Reports and initiating maternal and perinatal near-miss
reviews; Myanmar and Nepal on strengthening community involvement in MNH; and Sri Lanka developed a strategic plan for MNH.

11. Several important meetings were organized in 2008-2009. Issues addressed included: (i) continuum of care and partnerships in accelerating the achievement of MDGs 4 and 5 in the context of primary health care by strengthening the health system and involvement of relevant sectors; (ii) the need to review and develop country strategies for improving postnatal care and prevention and treatment of postpartum haemorrhage; and (iii) analysing sociocultural dimensions of MNH, and the way they are incorporated in programmes for improving MNH. As a follow-up to these meetings, countries disseminated the information nationally and took necessary actions to improve the quality of care for mothers and their newborns.

12. A major challenge faces the Region in relation to MNH human resources, especially in the four Member States that have a low proportion of deliveries assisted by a skilled attendant, where the number of health providers at community level with midwifery skills is usually inadequate and the quality of their services needs improvement. At the national level, databases on human resources for MNH are not well established and national plans are unclear, or available but not well implemented. Quality of MNH services is another challenge in most countries of the Region. While evidence-based guidelines have been adapted in most Member States, their utilization in daily practice at all levels remains an issue. Resource mobilization at the regional and country level, with a few exceptions (in Bangladesh and DPR Korea) remains a major challenge.
Reproductive health

13. Among the many elements of reproductive health, maternal and neonatal health continued to be a major issue in most SEA countries. The other key elements, such as family planning, prevention of unsafe abortion and sexually transmitted infections (STIs), contribute to the improvement of maternal and neonatal health. Countries with a high maternal and neonatal mortality usually also have a high fertility rate, low age at marriage and a high burden of teenage pregnancy. Many reproductive health problems are interrelated and therefore need an integrated approach to address them.

14. A framework for implementing the WHO-recommended Reproductive Health Strategy was published in 2008. Many Member States have adapted the framework or use it as a reference for the development of their reproductive health strategy. Technical support was provided to Myanmar to develop its Reproductive Health Strategic Plan 2009-2013.

15. The contraceptive prevalence rate varies among Member States. Figure 3.2 indicates that progress in many countries of the Region has been promising; however, Bhutan, Maldives, Myanmar, Nepal and Timor-Leste still have rates of less than 50%. The issues of expanding contraceptive choice, quality of family planning services, and unmet needs are being addressed. In this context, Timor-Leste was assisted in conducting a study tour for programme managers and partners to Indonesia to strengthen maternal and newborn health, as well as family planning programmes. India, Indonesia, Sri Lanka and Thailand were assisted in producing the Family Planning Wheel, which is a practical job aid for family planning service.

**Figure 3.2:** Trends in contraceptive prevalence rate, SEA Region, 1990-2008

16. Unsafe abortion is responsible for about 13% of all pregnancy-related deaths, while about half of the unsafe abortions in the world occur in Asia. Bangladesh managed to mobilize resources from the Royal Netherlands Embassy for a four-year programme on improving quality of menstrual regulation (MR) services in the country. The “Strengthening of National Menstrual Regulation Programme in Bangladesh” was then launched in 2008. NGOs working in this area are supported for improving access and quality of the service, especially in rural areas, as well as research on sociocultural aspects of non-use of MR services. DPR Korea was also supported in improving the capacity of health facilities to provide safe abortion care, while Thailand organized national and international meetings in prevention of unsafe abortion.

17. The integration of prevention and management of STIs/HIV infection into reproductive, maternal and newborn health services continues to be a priority. An intercountry workshop on the elimination of congenital syphilis was carried out in collaboration with the WHO HIV/AIDS programme with the participation of India, Indonesia, Sri Lanka and Thailand. A biregional workshop attended by participants from selected countries from the WHO Western Pacific and South-East Asia regions was organized to build capacity for writing proposals related to maternal and newborn health and other reproductive health issues for submission to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM).

18. As a follow-up of the Global Survey on Maternal and Perinatal Health, an intercountry meeting involving India, Nepal, Sri Lanka and Thailand was organized. It facilitated the discussion on how best to use the results of the Global Survey and identification of further research and interventions for improving maternal and perinatal health. Thailand followed this up with a national meeting among relevant stakeholders.

19. There are other reproductive health issues of interest to Member States, such as the review and development of national policies and guidelines on prevention and control of cervical cancer. Technical assistance was provided to Bhutan, DPR Korea, Maldives and Nepal for this purpose. The WHO guideline on essential practice on the subject was adapted. DPR Korea was also supported in improving health providers’ capacity in early detection and management of breast cancer, as well as in development of educational material on

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Family health and research

management of menopause syndrome. Sri Lanka was supported in producing an information book for newly married couples.

20. The achievement of universal access to reproductive health, as stated in Millennium Development Goal 5B, remains a challenge. Integrated services of various elements of reproductive health, especially at primary care level, need further strengthening. Monitoring of progress in achieving universal access to reproductive health at national and subnational levels is necessary, especially in the effort to achieve MDG 5.

Nursing and midwifery

21. The focus of work in nursing and midwifery during the biennium 2008-2009 was mainly on education, maternal and newborn health, nursing and midwifery workforce planning and management, nursing and midwifery services and regulation.

22. Efforts were made to improve the quality of nursing and midwifery education through advocacy, providing technical assistance to Member States and organizing the meeting of the South-East Asia Nursing and Midwifery Educational Institution Network (SEANMEIN). A case study to demonstrate the commitment and investment of the Government of India to nursing and midwifery education was developed. In the national eleventh Five-Year Plan, the government has included the policy and plan on nursing and midwifery education for the first time and has allocated substantial budget to build nursing schools and for the recruitment and development of teachers.

23. With support provided by the Regional Office, sets of models and mannequins along with textbooks were procured for nursing and midwifery schools in Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste for self-learning and skill practice.

24. The second meeting of SEANMEIN in April 2009 provided opportunities to share experiences on the global and regional initiatives in nursing and midwifery. Discussions included the role of educational institutions in nursing and midwifery workforce planning, quality assurance (especially in setting the standards of education), and the need for institutions to adapt curriculum to address the issues and trends facing the health systems and national health problems. A framework for public health/community health nursing education was also introduced.
25. While technical assistance is aimed to strengthen a three-year Diploma in Nursing and Midwifery in Bangladesh and Democratic People Republic of Korea, technical support is also extended to Member States that are implementing or planning to implement a degree programme for professional development. In this context, assistance was provided to the National University of Timor-Leste to implement two Bachelor’s degree programmes in nursing and midwifery, and the development of the Bachelor’s degree curriculum in nursing and midwifery for Bhutan.

26. With WHO support, the Faculty of Nursing, Khon Kaen University, Thailand, organized a regional training on community nursing and a study tour on the role of community-based health workforce in line with revitalization of primary health care. Support was provided to Bhutan to develop an information kit, with an emphasis on health promotion and disease prevention for community-based health workforce, including auxiliary nurse-midwives, and to organize national trainings on the information kit.

27. The work of the unit focused on advocacy for utilization of nurse-midwives or midwives at the community level, the strengthening of pre-service nursing and midwifery education and the training of existing nurse-midwives or midwives.

28. In collaboration with the Making Pregnancy Safer (MPS) and Reproductive Health and Research (RHR) units, an advocacy document on *Effective management of health workforce in accelerating the*
reduction of maternal and newborn mortality was produced and disseminated. Other activities included a regional meeting on sociocultural factors and MDGs 4 and 5; a review of the midwifery section in pre-service nursing and midwifery curriculum in Bhutan; national training of midwifery teachers in Nepal; and development of strategic directions for enhancing contribution of nurse-midwives for midwifery services in Bangladesh.

29. In collaboration with other units in both SEARO and WPRO, support was provided to the Asia-Pacific Emergency and Disaster Nursing Network (APEDNN). The network meeting in Cairns, Australia in 2009 demonstrated progress made with regard to the network website; core competencies of nurses and midwives in disaster preparedness and response; training courses; and a research framework.

30. Challenges remain. Strong professional leadership and unity and commitment by the government for strengthening nursing and midwifery is important in order for nurses–midwives be able to respond to the health needs of the people more effectively.

Child and adolescent health and development

Adolescent health and development

31. Adolescence (10-19 years) is a period of rapid growth and development. Adolescents constitute about 25% of the total population in countries of the SEA Region. Early marriage, early childbearing, undernutrition, sexually transmitted infections (STIs) and HIV/AIDS are major public health priorities in selected Member States of the Region. In order to achieve the Millennium Development Goals (MDGs) 5 (maternal health) and 6 (HIV/AIDS), it is important to focus on sexual and reproductive health of adolescents. Lack of access to information and health services hinders improvement in adolescent health. WHO has articulated a 4 “S” strategic framework to strengthen health sector response to adolescent health: strategic information; supportive policy environment; services and supplies; and strengthening collaboration with other sectors. Member States have adopted this strategy and WHO has provided assistance in the following areas:

32. Strategic information: WHO provided technical assistance to Member States to strengthen their epidemiological database on
adolescent health and HIV/AIDS in young people. Country factsheets for all Member States and national profiles in five countries (Bangladesh, Bhutan, Nepal, Sri Lanka and Thailand) were developed and disseminated. Sub-set analyses of existing national surveys (DHS, behaviour surveys and HIV surveillance, etc.) were supported in Bangladesh, India, Indonesia, Nepal and Sri Lanka, the reports of which are being finalized. All efforts mentioned above were found to be useful in advocating for increased investments in adolescent health and for provision of information and services to adolescents.

33. Supportive policy environment: With continued technical support from WHO, four countries (Bangladesh, India, Myanmar and Nepal) have developed national strategy on adolescent health. Youth policy in Sri Lanka is in the process of approval. Laws and policies affect access to information and health services for adolescents. Within the Human Rights framework and Convention of the Rights of Child (CRC), an assessment tool on laws and policies was adapted from the general tool of WHO in Sri Lanka. To share the tool and findings of Sri Lanka assessment, an intercountry meeting was organized in March 2009 in Colombo, Sri Lanka. In addition to adolescent health programme managers, legal officers/lawyers from Member States participated in the meeting; plans to conduct similar assessments and to develop guidelines for health providers were discussed. Subsequently Bangladesh completed assessment of laws and policies related to adolescent health.

34. Services and supplies: Tremendous progress has been made by Member States in implementation of adolescent/youth-friendly health services (AFHS/YFHS). Technical assistance was provided to develop a systematic approach to development, implementation and scaling-up of these services. Activities involving setting of national standards on quality of health services, implementation of guidelines to operationalize standards and adaptation of the training package for health providers, were completed in Bangladesh, Bhutan, India and Sri Lanka. Capacity building at national and subnational levels is being supported to implement AFHS/YFHS. Job-Aid (clinical algorithms for health providers developed by WHO) were field-tested in India.

35. Assessment of quality and coverage of AFHS/YFHS has been initiated in Bhutan, Bangladesh, India, Sri Lanka and Thailand. Technical assistance was provided for adaptation of quality and coverage tools, based on national standards. Results of the quality and coverage assessment conducted in selected sites have been obtained from India, Sri Lanka and Thailand. It is proposed to organize a regional meeting
to share the findings of assessment in selected countries and build capacity of remaining countries to adapt and use the tools according to the existing monitoring and supervisory mechanisms.

36. Technical assistance was provided for a national consultation to include adolescent health in the undergraduate curriculum of medical education in India. Job-Aid (clinical algorithms) have been adapted and printed for inclusion in the course for Postgraduate Diploma in Maternal and Child Health (PGDMCH) by the Indira Gandhi National Open University (IGNOU), New Delhi, India.

37. Strengthening collaboration with other sectors: Efforts have been initiated to build linkages between school health programmes and AFHS in Member States. An intercountry workshop on national nutritional surveillance was organized in July 2009 in Kathmandu, Nepal, to introduce the adolescent growth reference. Participants from both education and health sectors were invited. Selected countries were supported to implement the peer education programme to enhance demand-generation for services. In Bhutan, development and field-testing of modules on adolescent health for school health coordinators was supported. The modules have since been printed and released by her majesty the Queen of Bhutan.

**Child health and development**

38. WHO has extended technical assistance to Member States in the Region to contribute to achievement of MDG 4. A High-Level Consultation to Accelerate Progress towards Achieving Millennium Development Goals 4 and 5 in South-East Asia was organized in October 2008, one of the major recommendations of which was to strengthen maternal, newborn and child health through initiatives to strengthen health systems while addressing the contextually relevant social determinants.

39. Integrated Management of Child hood Illness (IMCI) continues to be the main vehicle to promote child health. Scaling-up of implementation to cover additional geographic areas has been achieved in seven Member States.

40. In-service training of health-care providers has been further strengthened in the countries implementing IMCI. Alternate methodology of training through computer applications (ICATT) has been expanded in Indonesia. Pre-service education of medical and nursing cadres has also been scaled up in Bangladesh, India and
Indonesia and review meetings were held to document progress and plan future actions.

41. Implementation of IMCI is likely to increase referral of sick newborns and children to hospitals for inpatient care. To strengthen inpatient care, initiatives to provide standard case management to sick children and newborns have been supported in Bangladesh, India and Indonesia. India has developed a training package for doctors and nurses to improve their competence to manage sick newborns and children in first-level referral hospitals. During the “Regional Workshop to Improve Inpatient Hospital Care of Children in South-East Asia”, a framework for improving quality of hospital care for children was developed. Subsequently, adaptation and initial application of tools for assessment of quality of care of sick newborns and children in hospitals has been strengthened in Indonesia and introduced in Bangladesh.

42. Periodic review of child health programmes at national and sub-national levels contributes to its effective planning and implementation. WHO has developed guidelines for conducting Short Programme Reviews (SPR) of child health to enable assessment of progress towards programme goals, objectives and implementation, to identify bottlenecks and develop recommendations for improving planning and implementation. The findings of SPRs were used in the development of a five-year national child health strategic plan in Myanmar, and in Bangladesh and Nepal, child health plans were strengthened as a part of the national health plans.
43. Fact sheets on child health have been developed to provide key information related to epidemiology, demographic indicators and coverage of the key child health interventions in all Member States. The fact sheets would be useful for high-level advocacy for informed planning to accelerate implementation of child health interventions to achieve MDG 4.

44. WHO has advocated with Member States to invest in the early childhood development (ECD) strategy, which focuses on the age group 0-3 years and ensures that children are exposed to age-appropriate psychosocial stimulation through communication and play activities, along with necessary health and nutrition interventions. A joint WHO-UNICEF “Regional Meeting on Promoting Early Childhood Development” was organized in Colombo, Sri Lanka in July 2009, where the global ECD package and a draft regional strategy on early childhood development were shared with representatives from SEA Region countries. The Regional ECD strategy is being finalized.

**Immunization and vaccine development**

45. At the end of 2009, India remained the only polio-endemic country in the Region. Recently re-infected countries remained polio-free: Bangladesh, Indonesia and Myanmar for more than two years, and Nepal for more than one year. India had 740 cases of polio, of which 79 cases were of type 1 poliovirus and 661 cases were of type 3 poliovirus mainly due to an outbreak in western Uttar Pradesh in the middle of
2009. However, the number of infected districts was reduced by a third from 2008 to 2009. An independent evaluation reaffirmed the high quality of polio surveillance and supplementary immunization activities that were being implemented in the endemic areas of western Uttar Pradesh and Bihar. The evaluation acknowledged the unique challenges of migratory populations, poor routine immunization coverage, high population density and poor sanitation.

46. The evaluation and discussions at global and regional level led to the development of a three-year (2010-2012) programme of work (PoW) to interrupt wild poliovirus circulation in India, with a focus on 107 high-risk blocks in the endemic areas. With support from WHO and partners, the Government of India in late 2009 intensified its efforts in these blocks through high-quality supplementary immunization using existing oral polio vaccines (tOPV, mOPV1 and mOPV3), routine immunization, and intensification of short-term sanitation activities.

47. The polio laboratory network, which consists of 16 accredited laboratories, continued to play a vital role in polio surveillance. In 2009, the regional network processed an incredible 110 000 AFP (acute flaccid paralysis) specimens within the global standard of 14 days for reporting results. The experience of the polio laboratory network was used to further strengthen the regional laboratory surveillance for measles/rubella, Japanese encephalitis/acute encephalitis syndrome, and sentinel laboratory surveillance for invasive bacterial disease and rotavirus.

48. In polio-free countries in the Region, the challenge remains to maintain high levels of OPV immunization through routine immunization and sustain high-quality AFP surveillance. WHO periodically conducted risk assessments for all Member States, which guided decisions for conducting national surveillance reviews. EPI and VPD surveillance programme reviews (with a focus on AFP surveillance) were conducted in Myanmar and Indonesia in 2008 and 2009, respectively.

**Measles**

49. The Regional measles consultation in August 2009 in New Delhi confirmed that all countries in the Region except India had achieved or exceeded the 90% measles mortality reduction goal. It recommended a goal of eliminating measles from the Region by 2020. All Member States conducted measles surveillance with the support of a regional network of 20 measles/rubella laboratories, of which 18 were accredited. In
2009, the national surveillance systems in Bhutan, DPR Korea, Maldives and Timor-Leste did not detect any suspected measles outbreaks. Seven states in India began case-based surveillance with laboratory confirmation for suspected measles outbreaks.

50. Although the Region achieved measles routine immunization coverage of about 75% and completed catch-up campaigns in all countries except India and Thailand, approximately 9.9 million children born each year in 2008 and 2009 were not vaccinated against measles.

51. In 2008, according to WHO/UNICEF estimates Bangladesh, Bhutan, DPR Korea, Maldives, Sri Lanka and Thailand achieved greater than 90% DPT 3 coverage nationally. Myanmar and Nepal achieved greater than 80% DPT3 coverage. Indonesia and Timor-Leste achieved greater than 70% DPT3 coverage while India achieved greater than 60% coverage.

![Figure 3.3: DPT3 coverage in the SEA Region](image)

Source: WHO/UNICEF Estimates
Note: Timor-Leste was part of Indonesia prior to 2002

52. In an effort to further strengthen immunization practices and systems, WHO assisted ten countries in the Region to form national advisory committees for immunization practices and developed an orientation package for the committees. The committees will advise the government in immunization policy development and introduction of new vaccines and strategies. By the end of 2009, countries had either developed a comprehensive multi-year immunization plan or were updating existing plans during the biennium. Member States developed national curriculum for mid-level mangers and basic health workers, updated existing training materials and conducted courses.
These training activities were linked with measles supplementary immunization activities. In India, technical assistance was provided to conduct a survey to assess the performance of health workers who received immunization training in seven low-performing states. Four Member States (Bangladesh, Bhutan, Nepal and Sri Lanka) introduced Haemophilus influenzae type b vaccine in their national immunization schedule. In order to better understand the disease burden for recently developed vaccines, laboratory surveillance sites comprising four rotavirus and six invasive bacterial diseases (IBD) laboratories were established in Bangladesh, Indonesia, Myanmar, Nepal and Sri Lanka.

53. Despite these achievements, over 10 million children in the Region do not receive DPT3 vaccination during their first year of life. The trend for DPT3 coverage appears to be stagnant at 72% since 2006. In India, 11 states account for 90% of the unimmunized for DPT3.

54. Many factors contribute to this situation including difficult terrain, inadequate human resources, suboptimal use of resources, poor transport facilities, extreme weather conditions, and the knowledge, attitudes and behaviours of clients and immunization service providers, as well as the occurrence of adverse events following immunization (AEFI). In the past two years, as a result of WHO assistance, nine Member States established a national AEFI committee. The committees in India, Indonesia, Nepal and Sri Lanka received training on causality assessment of AEFI.
55. Three of 11 Member States have a functional National Regulatory Authority (NRA). Twenty workshops and meetings were conducted for training 68 NRA/National Control Laboratory (NCL) staff in regulatory functions. The Regional Working Reference Standards (RWRS) for pertussis were developed. Studies on RWRS for JE and mOPV1 have been initiated. Four countries conducted injection safety assessment and developed policies to strengthen injection safety in immunization settings. One country conducted a study on risks associated with the needle pullers device for sharps management.

56. A regional strategic framework for improving and sustaining immunization coverage was drafted and circulated among all stakeholders. In the area of vaccine supply and quality, the focus was on strengthening national regulatory authority capacity and preparing the RWRS. Efforts were also made to establish and harmonize injection safety policies. Systems and tools were developed for Effective Vaccine Stores Management (EVSM).

**Nutrition and food safety**

57. The ninth South-East Asia nutrition research-cum-action network (SEA-RCA) meeting was organized in 2008 where the emerging issues of increasing food prices and their impact on nutrition and food security and the persistence of iodine deficiency disorders (IDD) were

National IDD capacity has been strengthened through training programmes.
discussed. A key recommendation was to strengthen the capacity of Member States to gather accurate, representative and frequent data on nutrition and food security and support the national IDD monitoring and quality control mechanisms. Technical assistance in understanding and formulating nutrition, food safety and security interventions in response to climate change and its impact on food production, availability and consumption was provided to six Member States: Bhutan, India, Maldives, Nepal, Sri Lanka and Thailand.

**Box 3.1: Strategic Focus in Nutrition & Food Safety:**

1. Policy formulation and operationalization of integrated nutrition, food safety and food security;
2. Surveillance and intelligence for effective management and monitoring;
3. Programme guidance on evidence-based interventions.

58. The national food safety programme and the iodine deficiency disorders (IDD) control programme of Thailand and the national IDD control programme of Sri Lanka were reviewed in terms of their policy and implementation content; the recommendations emanating from these assessments were shared and discussed with the highest-level health policy and programme personnel in these countries.

59. Participants from the Region were trained in the newer concepts of monitoring of urinary iodine and quality control of salt iodization at a regional workshop. The national IDD control and prevention programmes in Myanmar and the Democratic People’s Republic of Korea received support in the form of training of laboratory staff, standardization of laboratory techniques and provision of necessary equipment. Additional technical assistance was provided in designing the national IDD survey in the Democratic People’s Republic of Korea.

60. A new initiative known as “Landscape Analysis” to assess the capacity of Member States to respond to high levels of chronic malnutrition—stunting—in young children was piloted in Timor-Leste. The Regional Office and Member States also participated in the global review of food and nutrition policy survey.
Family health and research

Figure 3.4: Proportion of households using adequately iodized salt (Target ≥ 90%)

Sources: DHS surveys of various years / UNICEF MICS / ICCIDD SEA Regional Office / Annual Report

Figure 3.5: Status of adoption of the WHO new Child Growth Standards (0-5 years)

Sources: WHO-SEARO Questionnaire Survey (2009)

61. A nutrition programme relies on accurate nutrition intelligence and a surveillance system for effective monitoring and assessment of programme interventions. This strategic focus was achieved through a series of activities, starting with training in the use and interpretation of WHO growth standards for young children in India, Myanmar and Nepal. A regional workshop on the nutrition surveillance system was organized with the participation of representatives from Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand and Timor-Leste. Nine Member States in the Region have thus far adopted the WHO growth references for children under five years; the new WHO
growth references for children and adolescents are yet to be adopted by any Member State. The existing nutrition surveillance systems in the countries of the Region remain limited in scope, range, frequency and accuracy.

62. Technical capacity to conduct food analysis and monitor food contamination was enhanced through training and procurement of laboratory equipment for the Food and Drugs Authority in the Maldives (MFDA).

63. With regard to programme guidance based on evidence-based interventions, the Regional Office was the first to introduce a training module developed by WHO Geneva, on preparing national food-based dietary guidelines, in three member states (Maldives, Nepal and Sri Lanka). An integrated breastfeeding and complementary feeding counseling course for health staff was introduced in Indonesia, Myanmar and Sri Lanka, also using a WHO module. Training for food inspectors was organized in the Maldives; an approach to healthy market places along a standard operating procedure was introduced in Indonesia; and food contamination/total diet studies were supported in India.

64. Several challenges lie ahead. Collaboration with partner organizations and stakeholders at the regional and country levels needs to be enhanced for effective dissemination and use of resources. Development of a regional strategy on nutrition with an integrated approach to food safety and security, preparation of a model nutrition surveillance system and regional food-based dietary guidelines are...
needed to assist Member States to develop their own nutrition policy, nutrition surveillance systems and food-based dietary guidelines. Appropriate nutrition education of policy- and decision-makers, as well as the general population, are a priority issue.

**Active healthy ageing**

65. Population ageing, defined as an increase in the proportion of persons aged 60 years and over, has emerged as a dominant demographic trend. The proportion of population 60 years and over is increasing in all 11 SEAR Member States and it is estimated that by 2050, in over half (55%) of the Member States, 20% or more of the population will be 60 years old or more. Also by 2050, it is estimated that average life expectancy at birth in the Region will be 75 years. These trends imply that the national social and health services will face demands in catering to an increasingly aged population.

**Figure 3.6:** Trend in the increase of proportion of population aged 60 years and more in Member States of the South-East Asia Region

66. Following several regional activities, SEARO organized a regional consultation on a strategic framework for active healthy ageing in 2009 to share relevant experiences on policies and programme interventions for strengthening active healthy ageing. The principal objective of the regional strategic framework was to provide technical support to the Member States in developing and implementing policies and programmes for active healthy ageing and old age care. Follow-up workshops to assist Member States in adapting the regional strategic framework and work on the national policy on ageing were planned.
67. Also, limited technical and financial support was provided to a NGO-based in New Delhi, India to promote age-friendly primary health care in selected communities with the involvement of family physicians.

**Research policy and cooperation**

68. To ensure WHO streamlining and effective implementing of research activities and harmonizing of the Regional Strategy on Research for Health and the Global Strategy, a SEARO Staff Dialogue Workshop on WHO Strategy on Research for Health was held in collaboration with WHO headquarters on 10-11 January 2008 at the Regional Office, New Delhi, India. The Asia-Pacific Preparatory Meeting for the 2008 Bamako Global Ministerial Forum on Research for Health, “Strengthening national health research systems”, was jointly organized by Health Systems Research Institute (HSRI) in collaboration and supported by SEARO, WPRO and WHO headquarters on 10-12 June 2008 in Bangkok, Thailand. This resulted in the “Bangkok statement on research for health” that was endorsed as the recommendations of the biregional preparatory meeting for the 2008 Bamako meeting.

69. The Thirty-first Session of the WHO South-East Asia Advisory Committee on Health Research (SEA-ACHR) was held in Kathmandu, Nepal on 21-23 July 2009. A draft regional and national strategy on research for health was developed. A SEA-ACHR sub-committee on vaccines and drugs development was established in September 2009. National research capacity for health and development in Maldives and

![The Thirty-first Session of the ACHR was held in 2009.](image-url)
Timor-Leste were assessed by consultants teams in December 2009 and an assessment in Bhutan was planned.

70. The Regional Task Force on Avian Influenza (AI) was established to formulate policy, strategy and priority areas for AI research. It held its first meeting in March 2008 in Bali, Indonesia. The Regional Task Force on Health Research Management and Capacity Building held its first Meeting in 2008. Ten health research management modules as a self-learning package were endorsed at the intercountry workshop on research management, in Bali, Indonesia on June 2008. Small grants were provided for country priorities meeting through WHO country offices for applications of those modules. Health Research Management workshops were conducted in Bhutan, India, Myanmar, and Nepal in 2008, and Bangladesh and Thailand conducted country workshops in 2009.

71. The Regional Office promoted international research ethics standards in collaboration with national medical research councils, national research institutions and the Forum for Ethical Review Committees in Asia and the Pacific (FERCAP). WHO supported the research ethics and ethics review committee (ERC) capacity of Member States through a series of international training courses on human research subjects protection, developing standard operating procedures (SOPs), and the Surveying and Evaluating Ethics Committees for International Standard Recognition programme. Various ERCs of academic and MoH institutions in eight countries in the Region joined the accelerated training workshops for worldwide recognition programme of the Strategic Initiative for Developing Capacity in Ethical Review (SIDCER/WHO TDR).

72. Out of fourteen ERCs, 11 new ERCs were recognized in 2008-2009. This resulted in a total of 14 ERCs, in Thailand (10), India (2), Indonesia (1) and Sri Lanka (1) that were recognized for international standard review systems by external evaluator’s teams from FERCAP/ SIDCER. The national ERCs in Bangladesh, Bhutan, and Nepal have made great progress in series training, developing SOPs and preparing for international evaluation and accreditation.

73. A regional workshop on “Capacity Building for the Ethical Review Committee of Health Sciences Research” was jointly organized by the multi-faculty ethical committees of Chulalongkorn University (ECCU), College for Public Health Sciences (CPHS) in collaboration with and supported by SEARO and WHO headquarters for sharing and harmonizing research ethics review systems and regulation, including training and networking in SEA Region countries (Bangkok,
19-20 October 2009). To promote and enhance countries’ research ethics capacity and knowledge sharing, WHO SEARO supported annual meetings of FERCAP in 2008-2009.

**Collaboration in research**

74. During 2008-2009, 15 meetings of the Regional Research Review Committee (RRC) were held. A total of 54 research proposals were reviewed; 45 proposals for small grant Tropical Disease Research (TDR) and 9 proposals for other sources. Of 54 proposals, 12 were approved for small grant TDR with a total budget of US$ 82,321. Twenty proposals were subject to modification and 22 proposals were rejected.

75. An important function of the Research Development Committee (RDC) is to conduct meetings to review the institution proposals for designation or redesignation as WHO collaborating centres (WHO CCs). During 2008-2009, 49 proposals for designation and redesignation of WHO CCs were reviewed, of which 23 proposals were approved; 2 centres were newly designated, 23 centres were redesignated and 1 centre was discontinued.

76. As of 15 January 2010, there were 86 active WHO CCs in the Region. The numbers of WHO CCs are highest in India (40) and Thailand (35) as shown in the table 3.1.

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77. Table 3.2 shows the distribution of WHO CCs in the Region by country and area-wise as follows: communicable diseases (30 CCs), family health research (22), noncommunicable diseases and mental health (18), health systems development (11), and sustainable development and environmental health (5). However, there are no WHO CCs in four countries in the SEA Region.

Table 3.2: Distribution of WHO CCs by country and area of work (as of 15 January 2010)

<table>
<thead>
<tr>
<th>Area of work / Country</th>
<th>BAN</th>
<th>BHU</th>
<th>DPRK</th>
<th>IND</th>
<th>INO</th>
<th>MMR</th>
<th>NEP</th>
<th>SRL</th>
<th>THA</th>
<th>TLS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable diseases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Noncommunicable diseases and social determinants of health</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Family health and research</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Health systems development</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Sustainable development and environmental health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>40</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>35</td>
<td>0</td>
</tr>
</tbody>
</table>

78. SEARO continued supporting, promoting, expanding and strengthening capacity of the network of WHO CCs and National Centres of Expertise as follows:

- The annual meeting of the General Assembly of Network for World Health Organization Collaborating Centres and Centres of Expertise in Thailand (NEW-CCET), was held on 20 June 2008 and 25-26 February 2009.

- A country workshop on information and technological communication for WHOCC designation and re-designation was held by the Network for WHO-CCs and National Centres of Expertise in Thailand (NEW-CCET), 4-5 November 2008.

- The Meeting of WHO Collaborating Centres of India was held on 12-13 November 2009. This resulted in recommending the establishment of a network of WHO CCs in India to promote research, training and updating of expert’s database.
WHO expert advisory panels

79. At present, Member States in the SEA Region contributing to the global EAPs are India (40), Thailand (17), Sri Lanka (7), Indonesia (5), Bangladesh (4), Nepal (2) and Myanmar (1). There are no experts in the EAPs from Bhutan, DPR Korea, Maldives and Timor-Leste.

80. Out of 796 EAP experts worldwide, 76 experts are from the SEA Region and represent 31 areas of expertise.

81. In terms of challenges and areas of work for future emphasis in the Region, WHO will focus on:

- country research capacity-building,
- strengthening health research management and governance,
- enhancing research ethical review,
- supporting research infrastructure to enhance the quality of health research,
- and strengthening health research networking and partnerships.
Environmental health and climate change

1. Awareness and understanding of the health impacts of climate change were increased through the various activities carried out during World Health Day 2008, which focused on climate change and health. Several high-level regional meetings were held: a climate change and health meeting in Bali, Indonesia in 2008, and a regional meeting on climate change and health in New Delhi in 2009. A working group on climate change and health was established in the
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Regional Office. Information booklets and advocacy documents have been produced and disseminated.

2. A high-level technical consultation on climate change and health was organized in the Region, as well as national workshops on climate change and health in several Member States—Bangladesh, India, Indonesia, Maldives and Timor-Leste—with WHO support. A regional workshop on climate change and food security also took place.

3. A retrospective study on the impact of climate change on rota virus and the collation of various reports on occupational health, heat stress and climate change were completed. These studies indicate linkages between climate variability and climate-sensitive diseases. Assessments to understand the impact of climate change on health systems and measures to reduce health effects were carried out in Bangladesh and Thailand.

Health and human rights

4. Human rights are an overarching and cross-cutting principle that is relevant to all public health work. All SEA Region Member States have ratified at least two human rights treaties, which recognize the right to health. As a UN agency, WHO also has an obligation to address human rights across all areas of its work to ensure that its public health guidance is not only consistent with, but also promotes and reinforces, the human rights obligations of the countries.
During the review period, a number of modest achievements were made in this challenging area. First, in order to improve the capacity of WHO and its Member States to integrate a human rights-based approach to health, a series of human rights orientations and trainings were organized for WHO-SEARO and country office staff, as well as for national counterparts. Second, a number of advocacy materials, such as assessment tools, fact sheets and publications, were developed and distributed in the Region. One major achievement in this type of advocacy work was the publication of the “Health and Human Rights Fact Sheet–Maldives”. Such fact sheets give an easy human rights reference point for public health work and provide a basis for initiation of national-level activities in this field. During the review period, technical assistance was also given to various units within SEARO and the country offices.

The countries’ capacity to mainstream human rights was strengthened also through various country-level activities. For instance, the Maldives Country Office closely collaborated with the UN country team, the human rights commission and other national stakeholders on a desk review of human rights issues in the health sector. In Nepal, a national workshop on the “Right to Clean Indoor Air” was organized. In Bangladesh and Sri Lanka, assessments of adolescents’ sexual and reproductive health from a human rights perspective were conducted, and in Indonesia a human rights assessment on maternal and neonatal health that was initiated in 2006 was continued at provincial level.

The focus of health and human rights work continues to be on the capacity building of WHO and of Member States to integrate human rights-based approaches in public health work, with the overall goal of establishing equitable and nondiscriminatory provision of health services to all.

### Occupational health

WHO provided assistance to Member States to improve the health of workers, to develop occupational health policy, assess national capacity in occupational health, and train health workers on awareness and skills to provide community-based occupational health services.

WHO’s effort to devise and implement policy instruments on workers’ health is guided by the Global Strategy for Occupational Health for All and the Global Plan of Action for Workers’ Health. A baseline study was undertaken in 10 Member States of the Region.
(all except DPR Korea) to assess their readiness to implement the recommendations of the global plan. Seven countries (Bhutan, India, Indonesia, Myanmar, Nepal, Thailand and Timor-Leste) had at least a policy framework, such as a national strategic document. Efforts have been made to assist other countries to develop their occupational health policies in line with the global recommendations. Occupational health status assessments were conducted in Bangladesh, Bhutan, Sri Lanka and Thailand which are being used as baselines for the 2010-2011 workplan.

10. Two officials from Myanmar and one official from Bhutan were provided short-term occupational health training at the WHO Collaborating Centre in Ahmedabad, India and Mahidol University, Thailand, respectively. In addition, a training of trainers manual developed as part of workers’ health and safety programme in Sri Lanka has been adapted and used in Bangladesh, Bhutan and Maldives to build capacity of health workers. Technical assistance was provided to Bhutan to review the occupational health situation and train stakeholders, including health workers, and to Bangladesh to develop the national occupational health policy (consultations on the draft policy are being undertaken in collaboration with ILO). Capacity to implement occupational health programmes was improved in Sri Lanka through the establishment of occupational health units in the Ministry of Health and one district health facility.

11. SEARO supported the participation of 26 regional delegates in the International Conference on Preventing Emerging Occupational and Environmental Risks in South Asia and Beyond. The conference, held on 17-19 December 2009 in New Delhi, was organized by the Centre for Occupational and Environmental Health, Maulana Azad Medical College, India, in collaboration with Collegium Ramazzini, Bologna, Italy and Drexel University School of Public Health, Philadelphia, United States, and WHO SEARO.

12. The three regional WHO CCs and SEARO participated in the global WHO CC network meeting and developed the global plan of action up to 2012. The updated plan of action gives greater focus on developing basic occupational health services, establishment of occupational health in the context of health systems, and addressing key areas of concern such as asbestos and silica exposure. Two of the three WHO Collaborating Centres on occupational health in the region, the National Institute of Occupational Health, India and the Bureau of Occupational and Environmental Diseases, Thailand were redesignated for a period of four years.
13. As part of the global programme on promoting the banning of asbestos and the elimination of silicosis, WHO provided technical support to Thailand to implement a national workshop on elimination of asbestos-related disease. An umbrella agreement was signed between WHO and United Nations Environment Programme (UNEP) on 7 December 2009 to implement the Strategic Approach to International Chemicals Management (SAICM) with support of US$ 219,456 to Indonesia and Thailand (divided between two countries) and US$ 232,539 for Sri Lanka. The project is aimed at providing technical support to strengthen national capacities for sound management of priority industrial carcinogens in the countries. The activities in these projects include development of national chemical profiles, setting priorities for sound management of industrial carcinogens, identifying preventive interventions and developing national programmes for sound management of priority industrial carcinogens.

14. The first phase of the establishment of a Chemical Helpdesk, which involved the setting up of the information weblog, identification of expertise to administer the project and communications to countries, was completed. The WHO CC, International Centre for Environmental and Industrial Toxicology, Chulabhorn Research Institute, Bangkok, Thailand where the Chemical Helpdesk is based was redesignated for a period of four years. Twenty-eight officials from India were trained at the National Poison Control Centre of Vietnam through fellowship mechanism.

External coordination—resource mobilization

15. The regional Programme Budget for 2008-2009 increased by 38.5% compared to 2006-2007. This significant increase was due to growth in voluntary contributions, which constituted 75% and 81.5% of the total Programme Budget in 2006–2007 and 2008-2009, respectively. In absolute terms, the voluntary contributions increased from US$ 291.9 million to US$ 439.1 million—a 50.4% increase.

16. With this high level of increase in voluntary contributions, and the global financial crisis in particular, resource mobilization in 2008-2009 to achieve this target was very challenging.

17. Resource mobilization and implementation was one of the key agenda items of the Subcommittee on Policy and Programme
Development and Management (SPPDM) and the meetings of WHO representatives with the Regional Director; a number of issues relating to resource mobilization were discussed and ways to strengthen it were recommended. SEARO and the country offices have improved their resource mobilization strategies and capacities. Almost all country offices have developed their own resource mobilization strategies or action plans; improved relations with current and potential donors/partners; and strengthened technical capacity in this area. The Regional Office has stepped up its technical support for country offices, for example in funding gap analysis, mapping of donors, designing strategy and action plans, donor relations, and provision of donor information, resource mobilization tools and training, and monitoring systems on voluntary contributions.

18. In spite of the rising challenges in resource mobilization, including global financial crisis, the total amount of voluntary contributions mobilized at the end of 2009 was $322 million. This represents a 78% achievement of the planned Programme Budget targets.

19. During the review period, 142 funding/donor agreements were concluded with 43 development partners, of which 28 projects were with USAID, 11 with UNOPS (3D Fund), 10 with AusAID, 10 with UNCERF, 10 with GFATM, 5 with CDC Atlanta, 5 with Italy, 4 with SIDA/Sweden, 4 with Norway and 4 with CDC Foundation, 3 each with DFID, GAVI, the Bill Gates Foundation and UNFPA, and 2 each with European Commission (EC) and Rotary International.

20. In terms of funding magnitude, the 10 top donors were USAID, UNOPS, the Bill Gates Foundation, Rotary International, the Republic of Korea, GAVI, CDC Atlanta, UNICEF, the Global Fund and the EC. In terms of WHO’s strategic objectives (SOs), the main areas of donor/partner funding were SO1\(^3\) (48%), SO2\(^4\) (24%), and SO5\(^5\) (13%); the remaining 14% was divided among the other 10 SOs.

21. For the first time, Member States, Thailand and Timor-Leste, have made voluntary contributions to other Member States of the Region, in particular through SEARHEF and human resources training, which have contributed significantly to regional solidarity.

22. Regional and country offices have also provided technical supports to the efforts of Member States in the Region for resource mobilization such as a donor conference (Maldives), a workshop on resource mobilization.

\(^3\) SO1: To reduce the health, social and economic burden of communicable diseases

\(^4\) SO2: To combat HIV-AIDS, tuberculosis and malaria

\(^5\) SO5: To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact
mobilization (Bhutan) and project development for GFATM and GAVI/HSS.

23. Emerging trends in donor funding include the rise in official development assistance (ODA) in 2008 and a bigger share of ODA for the health sector, more decentralization of donor funding at country level, and new funding mechanisms (multi-donor trust funds for the UN system’s joint actions at country level, for example). To ensure better financing, WHO has been developing its Corporate Resource Mobilization Strategy, which will focus on three key areas: ensuring coherent and consistent approaches to the current donors; expanding WHO’s income-base with emerging new donor countries, foundations and the private sector; and creation of a more enabling environment for resource mobilization through a strong WHO brand, improved coherence, effectiveness and efficiency in resource mobilization efforts.

Strategic alliance and partnerships

24. In the South-East Asia Region, WHO’s collaboration with the United Nations system and with other intergovernmental agencies and partnerships over the biennium reflects the Organization’s efforts to strengthen cooperation with a diverse and complimentary range of partners and stakeholders to improve health development outcomes at country level; and accelerate the achievement of the internationally agreed development goals, including the Millennium Development Goals, with particular emphasis on those related to health.

WHO collaborated with a wide range of partners and stakeholders.
Coordination and collaboration within the United Nations system

25. During the biennium, interaction with the UN system was guided by a two-pronged approach: the promotion of health as a contributor to national development, and increased coherence and effectiveness of the system’s contribution to national development processes.

26. The WHO regional offices for South-East Asia and the Western Pacific held a high-level meeting with UNICEF and UNFPA in July 2008 to strengthen collaboration in health sector at country level and ensure coordination between the UN agencies in the Asia Pacific region in supporting countries to achieve the health-related MDGs as well as joint approaches to advocate and support aid-effectiveness mechanisms.

27. An MoU was signed in 2008 by the UNEP\(^6\) Regional Office for Asia and the Pacific, SEARO and WPRO to enhance collaboration in health at regional and country levels. The MoU covers cooperation from 2008-2010 in support of the Regional Initiative on Environment and Health, aimed at strengthening cooperation between ministries responsible for environment and health, both within countries and across the Region. SEARO and WPRO renewed the existing collaboration with UNODC\(^7\) for an additional five years through an MoU governing the promotion of public awareness on the dangers of drugs. The project, which was successfully implemented in Indonesia, Myanmar and Thailand, addressed the advocacy and awareness-building challenges and opportunities in the Region, focusing on preventive education against the use of illicit drugs and the damaging impact of drug abuse on individuals, families and communities.

28. WHO’s Thailand Country Office has strengthened its engagement with UNESCAP\(^8\) and is actively engaged in the UN Regional Coordination Mechanism (UNRCM-AP),\(^9\) in which it co-chairs the health thematic working group with UNFPA and participates in the other working groups.

29. The Regional Office has been increasingly involved in the UN Regional Directors Team, (UNDG-AP),\(^10\) the primary objective of which is to support the UNCTs\(^11\) in the Asia and the Pacific Region to

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\(^{6}\)United Nations Environment Programme  
\(^{7}\)United Nations Office on Drugs and Crime  
\(^{8}\)United Nations Economic and Social Commission for Asia and the Pacific  
\(^{9}\)United Nations Regional Coordination Mechanism for Asia and the Pacific  
\(^{10}\)United Nations Development Group for Asia and the Pacific  
\(^{11}\)United Nations’ Country Teams in Afghanistan, Bangladesh, Bhutan, Cambodia, China, Democratic People’s Republic of Korea, Fiji, Indonesia, India, Iran, Lao PDR, Malaysia, Maldives, Myanmar, Mongolia, Nepal, Pakistan, Papua New Guinea, Philippines, Samoa, Sri Lanka, Thailand, Timor-Leste and Viet Nam
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achieve the Millennium Development Goals and other development objectives. In May 2009, the Regional Office participated in the first Consultations with the Resident Coordinators/UN Country Teams of the UNDAF countries for 2009.

30. A Regional ministerial meeting on the theme “Financing Strategies for Health Care” was held in March 2009 in Colombo, Sri Lanka, as part of the preparatory process for the 2009 Annual Ministerial Review (AMR). The report of the meeting was presented to ECOSOC at the high-level segment for the Council’s consideration.

31. WHO country offices continue to actively participate in the CCA/UNDAF\textsuperscript{12} and UN reform processes to harmonize operational development activities at country level. In 2008, a pilot training workshop on the 2005 Paris Declaration on Aid Effectiveness was conducted in Nepal, designed to enhance the capacity of WHO country offices to support Member State engagement in these and other partnership processes. The lessons learnt from this training have been incorporated in the finalization of an interactive training toolkit developed to scale up the capacity of countries and health development partners on harmonization and alignment.

32. The Regional Office has supported country office engagement in the CCA/UNDAF, including through active participation in the regional Peer Support Group (PSG). During 2008, UNDAF were signed in Bhutan, India, Nepal, Sri Lanka and Timor-Leste, ensuring through the CCS, that the health section is aligned with priorities in the National Health Sector Plan. Indonesia, Maldives and Myanmar (UNSF)\textsuperscript{13} underwent UNDAF development processes during 2009.

Collaboration with regional intergovernmental organizations

33. Intergovernmental organizations are increasingly important partners in health development. Initiated in the 1980s, the collaboration of the SEARO and WPRO with ASEAN\textsuperscript{14} has been based on the guiding principle of strengthening the core capacities of the national public health sector of their Member States in order to reduce the burden of disease, which threatens economic development, social progress and health security. A new MoU with clear modalities for implementation of a shared workplan was signed in 2009, which focuses on joint activities in areas such as prevention and control of communicable and noncommunicable diseases; health systems strengthening; food

\textsuperscript{12} Common Country Assessment and United Nations Development Assistance Framework
\textsuperscript{13} United Nations Strategic Framework
\textsuperscript{14} Association of Southeast Asian Nations
safety; climate change; emergency preparedness and response; and traditional medicine.

34. Collaboration with SAARC\textsuperscript{15}, formalized through an MoU in 2000, is progressing particularly in the areas of HIV/AIDS, tuberculosis, malaria and the Tobacco Free Initiative, as well as in joint SAARC-WHO publications.

**Relations with global partnerships and nongovernmental organizations**

35. The Regional Office is involved in a number of global health partnerships, such as GAVI\textsuperscript{16}, GFATM\textsuperscript{17}, the Stop TB Partnership, the Partnership for Maternal, Newborn and Child Health and the Roll Back Malaria Partnership. Nepal, one of 12 developing countries participating in the International Health Partnership and Related Initiatives(IHP+),\textsuperscript{18} in February 2009 became the first Asian country to sign an International Health Partnership National "Compact", which emphasizes aid effectiveness; national ownership and leadership; and equity and a focus on vulnerable groups, bringing the concept of IHP to a higher level.

36. Partnership dialogues for health sector cooperation on key health priorities and strategies for national development were facilitated during the Maldives Partnership Forum held in March 2009 by the Government of Maldives.

37. Collaboration with international and national NGOs has been strengthened in several programmatic areas. The Regional Office continues to enjoy a privileged relationship with the IFRC\textsuperscript{19}, exploring synergies particularly in the areas of disaster management; emergency preparedness and response; blood safety; and health information. In February 2009 the Regional Director and the Secretary-General of the IFRC met to review the collaboration between the two organizations and discuss ways to continue to strengthen the existing partnership and increase the scope of collaboration to other areas such as community rehabilitation, mental health and road safety.

\textsuperscript{15}South Asian Association for Regional Cooperation
\textsuperscript{16}Global Alliance for Vaccines and Immunization
\textsuperscript{17}Global Fund to Fight AIDS, Tuberculosis and Malaria
\textsuperscript{18}Launched in 2007 to accelerate action to scale-up coverage and use of health services, and deliver improved outcomes against the health-related MDGs and universal access commitments.
\textsuperscript{19}International Federation of Red Cross and Red Crescent Societies.
Foreign policy and global health

38. Recognizing the important relation between foreign policy and global health policy, WHO has continued to actively engage in the Foreign Policy and Global Health (FPHG) Initiative. Also, in April 2009, the Regional Director convened a brainstorming exercise on the role of WHO in global health governance. The outcome of the discussions were conveyed to the Director-General, and reflected the need to ensure that WHO is able to adapt to a rapidly changing external environment and position itself as a strong and credible global leader in health.

39. A Regional Consultation on UN Reform, Health and Development was held in Colombo Sri Lanka, attended by participants from the ministries of foreign affairs and health. The meeting provided a unique forum for the exchange of best practices and lessons learnt, as well as for exploring synergies between the work of the ministries of health and foreign affairs. A noteworthy conclusion of the meeting was the need for more frequent interaction and consultation between the ministries of health, foreign affairs, finance and planning to ensure that countries benefit optimally from their membership in UN system organizations, and are able to play a lead role in driving UN reform, coordinating external assistance, and assuring alignment of interventions with national development goals and strategies.

40. The intricate international health development landscape requires WHO to reinforce its ability to understand, interact with, and facilitate diverse partnerships and collaborations. This will remain a strategic priority for the Region, and will require concerted efforts to ensure the availability of sufficient and effective resources to pursue and broadening of these strategic partnerships.

Water, sanitation and health

41. Awareness and knowledge about safety of drinking-water has been substantially increased in Member States through various regional level and national level workshops and trainings. Foundations for scaling-up the introduction of water safety plans in three Member States (Bangladesh, Bhutan and Nepal) have been laid through the preparation of guidelines, manuals and strategies. Drinking water quality monitoring and standards have been strengthened in the Region. Water and sanitation masterplan, rainwater harvesting guidelines and guidelines for implementation for water, sanitation
and hygiene in schools have been developed for Maldives. Countries have developed water quality standards and monitoring guidelines for ensuring safety of drinking water.

42. Promotion of sanitation has been achieved through the participation of relevant government officials in a regional sanitation workshop and other high-level international conferences such as the South Asian Ministerial Conference of Sanitation (SACOSAN) and the East Asian Ministerial Conference on Sanitation (EASAN). Pilot projects to test the appropriateness of ecological sanitation options have been carried out in Bangladesh, Bhutan and Nepal. Total sanitation guidelines were developed for Nepal. The results of these pilots will support development of sanitation policies and strategies in these countries.

43. Government and civil society capacity was enhanced on identification and management of arsenicosis patients in Bangladesh. A training module on arsenocosis case detection, management and disease surveillance was developed and introduced to 12 government medical colleges and 2 private medical colleges in Bangladesh. Assessment of arsenic contamination in drinking water has been carried out in Thailand. Guidelines for diagnosis of arsenicosis for doctors have been developed.

44. Various advocacy materials on water and sanitation were produced, including an award-winning film on the river Ganga that highlighted issues of pollution, health impacts and preventive measures, and widely disseminated in Member States. Capacity to manage health-care waste has been strengthened in Member States through various regional
and national training programmes, mainly to increase understanding of roles and responsibilities across government departments and agencies and in the private sector. Studies on the replacement of mercury-based equipment in health centres and handling of electronic waste were completed in India. A study to evaluate costs of health-care waste management (HCWM) at different sizes of health facilities was completed in Bangladesh. The findings will be useful in planning sound HCWM and to request funding allocations from the government. Understanding of the global water and sanitation monitoring system was strengthened through a regional workshop, intercountry workshops and national consultations. These activities were useful in integrating water and sanitation core indicators into national census and demographic health surveys in India and Timor-Leste.

**Emergency and humanitarian action**

45. Three major events defined the work of WHO in the area of emergency and humanitarian action in the SEA Region in 2008-2009: Cyclone Nargis in Myanmar in May 2008, the post-conflict humanitarian situation in Sri Lanka starting in May 2009, and a major earthquake in Sumatra, Indonesia, in September 2009. During the biennium, the South-East Asia Regional Health Emergency Fund (SEARHEF) was used for the first time. This and other initiatives contributed to increasing country capacity in the areas of preparedness and response.

46. The idea of a South-East Asia regional fund for emergency action was a response to gaps that had been observed during previous emergencies that had highlighted the fact that help is usually needed immediately after an emergency—but the majority of donor funds usually arrive weeks later. SEARHEF was established in 2007 at the Sixtieth Session of the WHO Regional Committee for South-East Asia; Cyclone Nargis was the first emergency for which the fund was used. A total of $350 000 (the maximum allowed under the regulations) was disbursed, with an initial payment being sent within 24 hours of receipt of the official request. These funds were used to procure essential medicines and start key public health interventions.

47. Cyclone Nargis, a category 5 cyclone, swept through the Ayeyarwady delta in Myanmar on 2 May 2008 and left 130 000 dead or missing and 19 000 injured. Inaccessibility of the affected areas and lack of communication were among the significant challenges. Two-thirds of health facilities were damaged, and one in five were completely destroyed, leading to very limited access to medical care for the injured and suffering.
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48. The Regional Office coordinated to mobilise emergency health kits, body bags, chlorine tablets to purify water, as well as medical and surgical supplies like antibiotics, gloves and bandages. As the Health Cluster lead, WHO worked with over 50 partners to ensure that duplication of efforts was avoided, and the best use of resources was implemented. The health cluster addressed priority health issues such as early warning and surveillance, vector-borne diseases, mental health and psychosocial support, reproductive health, health systems, and tuberculosis.

49. The success of the effort was due to the unique approaches followed in this emergency: (1) It was co-chaired with an NGO (Merlin) and the Ministry of Health, thus better engaging all partners; and (2) the Association of Southeast Asian Nations (ASEAN) was also involved and played an important role in working to bridge any gaps between the international community and the Myanmar government.

50. According to the Ministry of Public Health of the Republic of Indonesia, more than 1117 people died, 788 suffered from major injuries, and another 2727 were treated for minor injuries after a 7.2 magnitude (Richter) earthquake hit Sumatra close to the capital, Padang on 20 September 2009. The earthquake damaged many health facilities including 10 hospitals, 53 community health centres (Puskesmas), and 137 Sub-Health Centres (Pustu). The response to this event was swift—more than 4810 health workers were deployed by the Ministry of Health to the affected sites. SEARHEF provided US$175 000 to Indonesia for the response to the earthquake. By day 5, WHO was present in Padang and was supporting delivery of health
services provided through SEARHEF. The health cluster was activated in Padang on 2 October 2009 and involved 51 international and national organizations. By December 2009, the process for recovery and rehabilitation was more formalized; WHO support is ongoing.

**Protecting health facilities from disasters: a priority for Health Ministers in South-East Asia**

51. One significant feature of all emergencies is the loss of health facilities at the very time when they are most needed. A global campaign was launched by WHO, the International Strategy for Disaster Reduction (ISDR) and the World Bank to make health facilities safe in disasters. The WHO Regional Office organized a Regional Consultation on Safe Hospitals in April 2008 to promote this goal. Various practitioners and experts in the field of emergency preparedness and response came together and recommended, as initial steps, to conduct national consultation workshops to discuss the issue across sectors and adopt national plans of action for safe hospitals. The theme for World Health Day 2009 was “Hospitals Safe from Disasters”, in the context of which WHO developed and disseminated various advocacy and technical materials in the Member States of the Region. Action on this health issue culminated in the Region’s health ministers’ adoption of the “Kathmandu Declaration on Protecting Health Facilities from Disasters” at their meeting in September 2009. Regional Ministries of Health and WHO offices in the Region are striving toward its implementation through assessment of health facilities, mass casualty management planning workshops and advocacy.

52. Efforts continued toward supporting preparedness through the framework of the South-East Asia Region Benchmarks for Emergency Preparedness and Response. A detailed monitoring tool was piloted for three countries, prior to full implementation scheduled for the biennium 2010–2011.

53. To address gaps in the collection, archiving and retrieval of health information during disasters, SEARO has set up a repository and network called the South-East Asia Disaster Health Information network (SEADHIN). A pilot repository was set up in three countries and in November 2009; an intercountry workshop with emergency and information managers was held in Jakarta to outline the steps in managing such a repository (based on the software Dspace).

54. Preparedness and operational readiness for WHO country offices (WCOs) was also another focus of action. A Regional Public Health Pre-Deployment Course was conducted in Jaipur, India for WCO staff to prepare them for emergencies.
Information management and dissemination

55. The work of the Information Management and Dissemination unit centered around the provision of WHO information resources; management and dissemination of national information assets; ensuring equitable access to global health literature; and strengthening information management infrastructure at WHO and in Member States.

56. All WHO publications in hard copy are made available, free of charge, through Depository Libraries and Reference Libraries of WHO publications in Member States. During the period nine additional reference libraries have been established, one reference library each in Bangladesh, Bhutan, DPR Korea, Myanmar and Timor-Leste, and two libraries each in India and Thailand.

57. Priced publications are also made available through “Special Display Corners” at major book stores in the Member States such as Sri Lanka and Thailand. In addition, the Publication Distribution System (PDS) was developed and integrated into WHO SEARO website, providing a comprehensive list of information materials produced in the Regional Office for the public to download or submit requests/orders.

58. WHO SEA Region Institutional Repositories were established in 2007 at the Regional Office and in all 11 country offices. The repositories provide online, open access to WHO information material in digital format. Two specialized digital repositories in herbal medicine (HerbalNet) and disease surveillance and epidemiology (DSE) were also been established in collaboration with Technical Units in WHO and partners in Member States. A Federated Search facility was developed that allows users to search for WHO information, in real time, from all SEA Region repositories with single search command.

59. In collaboration with national counterparts, two online digital journal portals have been established, for Myanmar and Thailand. These information portals provide one-stop access to health science journals published in Myanmar and Thailand, thereby improving visibility and accessibility of research findings.

60. A cumulative digital archive of articles from major health science journals in the Region—Index Medicus for South-East Asia or IMSEAR—has also been made accessible online. IMSEAR currently contains over 124 000 articles from 59 journals in seven Member States of the Region.
61. Six Member countries of the SEA Region—Bangladesh, Bhutan, Maldives, Myanmar, Nepal and Timor-Leste—are eligible for free or nearly free access to global commercial biomedical information services through the Health InterNetwork Access to Research Initiative (HINARI). During the biennium, HINARI training courses have been conducted in all HINARI-eligible Member States.

62. Three new health science libraries have been established at the Ministries of Health in Bhutan, Myanmar and Timor-Leste. In addition to infrastructural support, the Regional Office also provided core information material to the libraries. These health science libraries function as a primary source of WHO and global health literature in Member States.

63. To strengthen the initiative launched in 2004 to increase the Region’s capacity in public health education, the Regional Office has developed core lists of standard textbooks in public health, epidemiology and statistics, and nursing and midwifery, and provided information material to nine schools of public health in the Region. Similar support has also been provided to National Health Research Councils in Bangladesh and Nepal and the Public Health Foundation of India (PHFI).

64. Awards for study visits and training in information management and services at HELLIS national focal points in various countries were provided to 13 officials, four from DPRK and two from Bangladesh to visit Indonesia, two from Nepal to visit India, two from Myanmar to visit Thailand and three from Timor-Leste to attend a workshop on “virtual health library” in Brazil.

65. Training was also provided to staff members at the Ministry of Health, Indonesia, on the Integrated Library System and the Institutional Repository System after establishing the two systems at the ministry with WHO assistance. Following a request from the Government of DPR Korea, technical and infrastructural support was provided to upgrade the network infrastructure so as to improve communication and access to information among nine research institutions and hospitals located in different provinces of the country.

66. Building national capacity and sustainable information services and national health repositories are ongoing activities; securing adequate commitment from policy-makers, programme managers and administrators related to Health Literature and Library Information Services (HELLIS) is a continuing challenge, as is maximizing the use of HINARI resources.
National health planning and health financing

1. The global financial crisis of 2008-2009 gave further prominence to health financing as a key to protecting the health and development needs of the poor. SEARO is a member of the WHO Working Group on the Financial Crisis and Global Health set up by the Director-General. The Working Group is responsible for monitoring crises-related events and continued profiling of health, particularly among donors. Member States were briefed on developments at the Health Ministers’ Meeting in September 2009.
2. WHO-SEARO has continued its direct support to countries as well as capacity development at the regional level in the area of health economics and financing. The main activities included the following:

- In Bhutan, a multisectoral training in National Health Accounts was conducted.
- With SEARO technical support, Maldives has examined the potential for public–private partnerships in the context of the recent restructuring of health financing.
- In Myanmar, SEARO has developed and delivered a training on "Economic evaluation and impact assessment in health".
- In collaboration with local institutes, the health and related ministries, SEARO initiated health financing and expenditure reviews to assess policy needs and options to improve equity and efficiency. Such reviews are expected to become routine assessments, implemented regularly as part of an evidence-based policy process in countries. This activity was completed in Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand.

3. At the regional level, a course on “Economic principles for health policy and planning in low income countries” was developed and administered by international faculty in collaboration with the WHO CC for Health Economics, Chulalongkorn University, Bangkok in November 2008. A course on “Strategic purchasing for social protection” was given in collaboration with the same institute in December 2009. This seminar allowed countries to discuss technical issues and experiences on improving systems performance through the use of alternative provider payment mechanisms, including in the private sector.

4. A course on health financing issues in low-income settings was developed and administered by international faculty in collaboration with the Centre for Health Economics and Policy Studies, University of Indonesia, in Bali in March 2009. A course on economic evaluation and impact assessment in health was developed and delivered in Myanmar.

5. Products for a “Health Economics and Financing Intelligence Platform” were initiated. These included a glossary to promote common understanding of technical concepts; and policy briefs, technical notes and country updates from the courses and health financing and expenditure review also noted above.
6. SEARO reviewed its own Biregional Health Financing Strategy 2011-2015 with WPRO based on inputs from countries and development partners. The strategy has been aligned with the Organization’s recent work on primary health care and social determinants of health; it underlines the urgency for social protection, especially for the poor, in the context of the financial and economic crises.

7. The Sixty-second Session of the Regional Committee for South-East Asia adopted a resolution on “Engaging private sector in providing health services to meet national health systems goals” in 2009, calling for improved government regulation of private sector activities so as to integrate their contributions more effectively in the national health agenda.

**Health system infrastructure**

8. The emphasis of WHO’s work in this area has been to support countries in: strengthening health systems as part of the revitalization of primary health care and health services management; working with the Global Alliance for Vaccines and Immunization in Member States on health systems strengthening; and enhancing the Public Health Initiative network.
9. In April 2008 in Bali, Indonesia, a Workshop for Trainers on District Health Management Development was carried out to build capacity and strengthen management in health organizations at the subnational/district level. It was decided to revise the draft modules on strengthening health service management to serve as a “guideline on strengthening health service management” and give a more operational focus.

10. The conclusions and recommendations of the Regional Conference on Revitalizing Primary Health Care in Jakarta, Indonesia, in 2008 were endorsed by the Sixty-first Session of the Regional Committee for South-East Asia in September of that year. One of the important conclusions of the Regional Committee was that in the SEA Region, the service approach should be replaced with a development approach. As a follow up, the Regional Office has collaborated with an experienced team in Thailand to support countries in revitalization of PHC.

11. A regional consultation for self-care was convened in Bangkok Thailand in early January 2009, which recommended that Member States include strengthening of self-care as a programme in their efforts to revitalize PHC. Other agreed necessary actions were to re-examine national health policies and strategies to strengthen support structures, legislation and financing for self-care; to document existing local self-care best practices and conduct operational research; and to establish a network of individuals and institutions for self-care promotion. Work began on a handbook for lay persons and community-based health workers (CBHW) and community health volunteers (CHV) to be published in collaboration with the Voluntary Health Association of India.

12. A rapid assessment guideline for health systems strengthening was developed using a team approach for extending technical assistance to countries. The rapid assessment guideline was field tested in Sri Lanka and shared in a biregional SEARO-WPRO meeting. The guidelines for conducting rapid assessment of health systems in the SEA Region has been developed and field-tested in Indonesia and the document is in its final stage.

13. A Regional Meeting on Health-care Reform for the Twenty-first Century in South-East Asia Region was held in October 2009 in Bangkok, Thailand, which proposed that health-care reform should promote public health with a good balance between medical care on curative aspects and health promotion and disease prevention.
The Work of WHO in the South-East Asia Region

Health systems development

The South-East Asia Public Health Education Institutions Network (SEAPHEIN) was supported by WHO in such areas as accreditation and research collaboration. SEAPHEIN is being encouraged to support development of country “PHEIN”; progress made so far is establishment of “Thaiphein”, “Lankaphein” and “Indophein”. SEAPHEIN is moving for their own resource mobilization by organizing PH courses.

Public Health Initiatives: A PHI website has been created which contains curriculum for PH education. SEARO is currently supporting establishing the Bachelor of PH (BPH) programme in Bhutan.

Promoting public health to improve health equity is an ongoing priority. The challenges to health systems include a shortage of capable district health managers, the need to enhance the competency of community-based health workers and community-based volunteers, and improvement in the organization and management of health services delivery.

Human resources for health and fellowships

Sufficient numbers of well-trained motivated health workforce are essential to improve health outcomes. There is a critical shortage of health workforce in SEA Member States, and WHO is working in close collaboration with the countries in their capacity building for a sustained health workforce (HWF) development.

Bearing in mind the importance of HWF strategic planning, Regional Guidelines for Development of Health Workforce Strategic Plans in Countries of the South-East Asia Region were developed, which identify and define different types and categories of HWF. With a view to making significant improvement in public health teaching, Guidelines for Preventive and Social Medicine/Community Medicine/Community Health Curriculum in the Undergraduate Medical Education were developed.

Holistic development of professionalism in HWF includes knowledge of the ethical issues faced in everyday clinical practice and research. In view of the little progress made by SEA Region countries in this area, a Module for Teaching Medical Ethics to Undergraduates was developed, identifying the key components for an undergraduate
curriculum, and a *Handbook and Facilitators’ Guide on Medical Ethics* was also developed to assist teachers in medical colleges.

20. Other guidelines that were developed during the period under review to support Member States include *Guidelines for Accreditation of Medical Schools in Countries of SEAR*, produced in consultation with the Network of Medical Councils of SEAR Countries and also involving World Federation of Medical Education (WFME); *Regional Guidelines on Institutional Quality Assurance Mechanism for Undergraduate Medical Education*; *Guidelines and tools for continuing medical education*, to help facilitate continuous professional development of health professionals.

21. Retention of health workforce is important to ensuring sustained delivery of health-care services. A draft code of practice on the international recruitment of health personnel was reviewed in a regional consultation with Member States and all relevant partners. Between the review Member States held national consultations on the said draft. The Member States arrived at a regional perspective on the various clauses of the proposed draft code. There was unanimous acceptance among the Member States of the need for the Code of Practice, including its endorsement in the World Health Assembly. The outcome of the Regional Consultation was shared with WHO Headquarters.

22. A regional meeting on Teaching of Public Health in Medical Schools was organized in December 2009 in Bangkok, Thailand to strengthen the content and teaching methodology of public health subjects in undergraduate medical schools, and to encourage better recognition of public health issues among medical students.

**Fellowships**

23. Fellowships are a proven mechanism for supporting countries in their institutional and health system capacity building. During the period under review, 901 awards were issued against 1035 fellowships applications received; 46 awards were cancelled and 88 applications withdrawn (see Table 5.1):
Table 5.1: Fellowships awarded during the biennium 2008-09

<table>
<thead>
<tr>
<th>Member State</th>
<th>No. of Fellowships applications received</th>
<th>No. of Fellowships awarded</th>
<th>Awards Cancelled</th>
<th>Fellowships Applications Withdrawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>85</td>
<td>74</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Bhutan</td>
<td>61</td>
<td>56</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>200</td>
<td>153</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td>India</td>
<td>270</td>
<td>223</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Indonesia</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maldives</td>
<td>86</td>
<td>76</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Myanmar</td>
<td>173</td>
<td>169</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Nepal</td>
<td>65</td>
<td>62</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>77</td>
<td>72</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Thailand</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1035</strong></td>
<td><strong>901</strong></td>
<td><strong>46</strong></td>
<td><strong>88</strong></td>
</tr>
</tbody>
</table>

24. There has been a perceptible shift from clinical fellowships to public health fellowships. Over the bienniums, there was an increase from 59% in 2002-03, to 72% in 2004-05 and 73% in 2006-07. Of the 901 awards issued during 2008-09, 625 (69%) were for study/training in public health, versus 276 (31%) in clinical areas. This highlights the continued efforts of the Region’s Member States in building capacity and competence in public health.

25. Of the 901 awards issued, 742 (82%) were regional and 159 (18%) were for training in countries outside the Region. Training institutions in India and Thailand continued to attract the majority of fellows. There has been encouraging number of nominations of female candidates; of the 1035 candidates nominated during 2008-09, 624 (60%) were male and 411 (40%) female.

26. In terms of collaboration with other regions, 159 fellows from the SEA Region undertook fellowship trainings of varying durations in countries of the Western Pacific, Eastern Mediterranean and American regions. Similarly, 70 fellowship requests from the Western Pacific Regional Office and 52 requests from the Eastern Mediterranean Regional Office were received for fellowships training in countries of the SEA Region.
27. Other activities during the biennium included development of a regional HWF observatory, to gather information for the use of countries in human resources policy development, planning and research. The Regional Directory of Training Institutions (RDTI) was also updated. RDTI currently contains 111 institutional, 208 departmental, 806 faculty and 514 training profiles.

**Essential drugs and other medicines**

28. Medicines are an essential component of health care systems and their management requires many different functions including regulation, selection, procurement, supply and rational use.

29. Selection according to an essential medicine list is very important to ensure that the most cost-effective safe medicines are used. Following a regional workshop held late in 2007, Bangladesh, Indonesia, Maldives, Sri Lanka and Timor-Leste updated their Essential Medicine Lists in 2008. Timor-Leste elected to use a “bottom up” approach to develop a new EML (as opposed to modifying their previous list) this being more time consuming but more sustainable as it involved participation of health care professionals who now own the process. India initiated revision of its 2003 essential medicines list and they plan a more participatory process than previously, including 4 regional workshops and a final one in Delhi. In addition, some individual states of India are revising their own lists and there are plans to develop a national Essential Medicines List for Children during 2010.

Innovative approaches are being taken by Member States to improve access to medicines.
30. Medicine prices heavily influence access to medicines. At a regional meeting on medicines prices in November 2008, it was realized that regulation of prices is essential to ensure access to medicines and cannot be left to the market alone. While Ministries of Health are now convinced of the need to regulate medicines prices to achieve health, other ministries such as trade and industry, with different agendas, still need to be convinced. Various innovative approaches were discussed and are now being undertaken by countries to improve access to medicines. India has focused on supplying affordable medicines to specific government-sponsored shops selling generic medicines and to medicines shops in hospitals run by certain civil society organizations. Indonesia is evaluating the possibility of providing generic medicine names and prices through text messages on mobile phones.

31. An innovative “Patent Pool” is being developed globally by UNITAID in cooperation with the pharmaceutical industry and using the full, public health provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to increase access to HIV/AIDS medicines for patients in the developing world. The first (and so far only) regional meeting on the Patent Pool was held in SEAR in June 2009. There was extensive participation by the industry and with civil society organizations. It also provided an opportunity for SEAR countries to improve the capability of their national pharmaceutical industries.

32. Eight SEAR countries participated in the 13th International Conference of Drug Regulatory Authorities (ICDRA) in November 2009, which was supported by all levels of WHO. The UN prequalification (PQ) system for medicines (coordinated by WHO) provided an opportunity “to learn by doing” through observation of inspections. This greatly benefitted the SEA Region, which has the most manufacturers for the UN PQ system. The issue of combating counterfeit medicines was extensively discussed by the Regional Committee, which adopted a resolution focusing on access to effective, safe and affordable medicines of good quality through better medicines regulation that included combating counterfeit and substandard medicines. The recommendations adopted in the regional resolution were taken forward by the regional Member States for discussion at the World Health Assembly in 2010.

33. Pharmacovigilance (monitoring adverse drug reactions and events) is increasingly important as new medicines are now being introduced to all countries simultaneously (so that developing countries can no longer rely on information on benefits and risks from previous use
of new medicines in developed countries). A regional meeting on improving pharmacovigilance was held in September 2009 for countries to either start or improve national surveillance. India discussed how to coordinate its national system with the Global Centre operated by WHO.

34. Promoting rational use of medicines remains a priority for the region. Regional training courses were supported on Promoting Rational use of Medicines in the Community and Drug and Therapeutic Committees – mainly for participants from SEAR countries but also including participants from outside the region. The WHO Model Formulary was printed and distributed to some countries, some of whom do not have the expertise to develop their own national formulary. India developed a draft National Formulary based on the WHO formulary which has enormous potential for rational use when finalised. Activities were supported in a number of SEAR countries on patient education including the development of patient formularies (independent unbiased information for patients) and projects to improve knowledge or use of medicines in pregnant women, school children and the elderly. A meeting to share experiences and lessons learnt from these projects is planned.

35. Traditional medicine (TM) is widely used in SEA Region. In developing evidence-based information on quality, safety or efficacy of TM products, exchange of information and inter-institutional cooperation was initiated. A list of traditional medicine departments, teaching, health-care service and research institutions has been established. TM pharmacopoeias and national formularies were exchanged. To facilitate this process, a website called HerbalNet was set up. Publications exchanged include national policies on TM/HM and the use of TM/HM in primary health care (PHC). To promote the use of herbal medicines (HM), a regional meeting on the use of herbal medicines in primary health care (PHC) was organized. The recommendations of the meeting facilitate strengthening of research on quality, safety and efficacy of herbal medicines, inter-country cooperation and conservation and sustainable utilization of medicinal plants. Guidelines for the use of HM in PHC have been developed in India and Indonesia. Nepal has developed guidelines for TM providers to promote patient safety.

36. All SEAR countries are working towards improved management of medicines leading to improved health care.
Intellectual property rights and trade and health

37. The potential impact of intellectual property rights—notably patents—on access to medicines is an issue of concern for Member States. Work in this area has focused on increasing awareness and knowledge among health officials as well as officials from other sectors, and on building or increasing capacity in Member States to analyse and address the public health implications.

38. In order to achieve this, national workshops were conducted, with support from WHO’s Regional Office, in Bangladesh, Indonesia, Maldives and Myanmar. These workshops not only increased participants’ knowledge, but also facilitated intersectoral dialogue, which is crucial given that sectors other than health have the primary responsibility for developing policies and drafting laws and regulations on issues such as intellectual property rights and trade. Whenever feasible, selected experts from the region were invited as resource persons, in order to share and learn from regional experiences and insights.

39. An executive course for policy-makers from the Region was organized in collaboration with the National Law School in Bangalore, India. This interactive course, in which policymakers from nine countries in the Region participated, sought to strengthen national capacity to design and implement intellectual property policies consistent with public health needs. Materials prepared for and used in this course were adopted by an Indian institute for a national course.

40. In order to reach a wider audience, a number of briefing notes and reports on intellectual property and public health were published. These included the reports “Intellectual property rights and access to medicines: a South-East Asia perspective on global issues” and “International trade and health: a reference guide”; the latter document has proven valuable in the SEA region and has also been distributed in two other WHO regions. Other documents and reports published in the biennium explore current themes such as virus sharing and the definition of “counterfeit” medicines/medical products.

41. These activities have contributed to raising the awareness and understanding of the public health implications of international trade and intellectual property rules among health policy-makers in the Region, which has been one of the factors that enabled the SEA Region
to speak with one voice during the intergovernmental discussions that resulted in the WHO Global Strategy and Plan of Action on public health, innovation and intellectual property. Similarly, an important step has been taken at the sixty-second Regional Committee meeting held in September 2009, which adopted Resolution SEA/RC62/R6 on “Measures to ensure access to safe, efficacious, quality and affordable medical products”. The resolution stated that “counterfeit” medical products should not be equated with substandard medical products and urged Member States to implement trade and intellectual property policies without constraining policy space for health.

42. The main challenge for the future lies in the fact that international rules and agreements on intellectual property rights are rapidly changing. Demands for countries to provide a higher level of protection to intellectual property than what is required by the World Trade Organization’s TRIPS Agreement can negatively affect public health and access to medicines. Such demands (sometimes referred to as “TRIPS-plus” requirements) are for instance made in the context of bilateral or regional trade negotiations with developed countries. In combination with the diversification and expansion of the number of organizations and forums where intellectual property issues are being discussed and negotiated, this poses important challenges for health policy-makers.

**Gender and women’s health**

43. The development of a gender mainstreaming Plan of Action (POA) 2009–2013 in health for the South-East Asia Region was finalized in the Inter-working Group on Gender Mainstreaming in Health (IWGGM) in the Regional Office. Countries of the Region have set their own priority areas regarding health inequity, but 9 out of 11 countries have highlighted gender-based violence (GBV)—the leading gender and health issue in the Region.

44. International Women’s Day (IWD) on 8 March 2009 celebrated progress in women’s advancement. The book *Combating Gender-based violence (GBV) in South-East Asia, Highlights of 2006-2008*, was published to push forward the elimination of GBV in the region. The multisectoral approach in GBV was promoted and implemented. From two countries in 2008, the number of countries implementing this approach rose to four in 2009 (Indonesia, Nepal, Sri Lanka and Thailand). One-stop crisis centres (OSCC) are one of the best tools
Member States are giving priority to improve gender and health equity.

in the health sector response to GBV. The multisectoral guideline giving best practices of OSCC, developed in Thailand, has provided a conceptual framework covering roles and responsibilities of health providers, police, prosecutors and social workers to handle gender-based violence cases, not merely for secondary prevention but for primary prevention as well. Data collection and analysis was carried out in relation to combating GBV.

45. SEARO supported the development of a gender-sensitive “Are you well?” programme for women patients in hospital with HIV/AIDS and tuberculosis in Chennai, India. The aim was to increase women’s awareness and self-care for HIV/AIDS and TB and to combat stigma. This women’s empowerment programme utilized radio, role-playing and focus group discussion in the hospital. It provides tools for health providers to understand and overcome barriers.

46. To support gender mainstreaming in the Region, during 2009 multisectoral guidelines on GBV primary prevention were developed. Gender and health partnership skills training, a week-long training programme, was carried out for WHO technical units in the regional and country offices. Seven areas of model development were identified in a unique regional initiative. It is hoped those products could be utilized by SEAR countries to support the implementation of gender mainstreaming in health.
Health situation and trend assessment

47. The Regional Programme on Health Situation and Trend Assessment: Strengthening Country Health Information for 2008-2009 was developed in response to recommendations of the Sixtieth Session of the Regional Committee for South-East Asia, which urged that evidence-based health information should be instituted for formulating policies and initiating effective interventions, particularly with focus on disaggregated data at subnational levels. The committee urged Member States to use the Regional strategic plan for assessing country health information systems and to track progress of the MDGs.

48. The Regional Office, together with the Health Metrics Network, assisted countries to assess their health information systems (HIS) and encouraged them to realign the country HIS with regional strategies for strengthening health information systems. Bangladesh, Bhutan, Indonesia, Myanmar, Sri Lanka and Timor-Leste were supported both technically and financially in these endeavours.

49. The Regional consultation on “Utilization of Health Information for Decision-Making” was conducted to review the progress of strengthening country health information systems and to identify way forward. The resulting recommendations for WHO have largely been implemented and Member States were supported to further strengthen country HIS.

50. Adoption of international standards is very important for producing good quality clinical data required for national health information systems. The Regional Office is promoting the use of the WHO Family of International Classification (WHO-FIC) and especially the ICD-10 (International Classification of Diseases and Related Health Problems, 10th Revision). In Maldives, a national training-of-trainers workshop on ICD-10 was supported. This classification was promoted in Indonesia, Nepal and Timor-Leste, to be used in all their hospitals to code clinical diagnosis and to code cause of death at national and subnational levels. The Region is handicapped in terms of technical skills in ICD training and research. The first WHO Collaborating Centre in WHO-FIC was established in India in 2008, and Sri Lanka and Thailand are in the process of designating two more centres.

51. Recording of vital events, especially registering all births and deaths, is very important to produce vital statistics, and many
health indicators use them for denominators. Hence a good vital registration system has a paramount importance both for countries and international and UN organizations. WHO HQ developed a tool to assess country Vital Registration System (VRS), which was pilot tested in Sri Lanka in 2009, in which WHO SEARO provided the technical support. The tool has now been finalized and will be used globally to assess VRS of Member States.

52. To provide reliable information for all concerned with the health sector, the *Health Situation in the South-East Asia Region 2001-2007*, the fourth in the series since 1991, and the biregional *Health in Asia and the Pacific*, were published in 2008.

53. A SEARO Task Force for monitoring the achievement of health-related MDG in the Region has been established. It submitted reports to the Health Ministers’ Meeting in 2008 and reported on follow-up actions in 2009. Key issues that were highlighted were the importance of analysing and presenting data at subnational and district levels, and by social determinants to identify inequities and to plan and implement interventions. The regional workshop on “Strengthening use of Health Information at the District Level” was held in 2009 in Bangkok, Thailand to address the country capacity building in data analysis, presenting and use at sub-national levels and district levels.

54. A working collaboration was developed with Queensland University of Technology and proposed WHO Collaborating Centers in International Classification of Diseases in Thailand and Sri Lanka to build regional and country capacity to conduct !CD-10 training in the Member States.

55. The following challenges need to be addressed:

- Strengthening of vital registration systems of Member States to produce better information on birth and death registration as well as to improve cause of death information.

- Building country capacities in data analysis, presenting and use of health information for decision-making at district and sub-national levels as well as monitoring of the progress of achieving MDGs at district and sub-national levels.

- Need of introducing Information Communication Technology, including eHealth for health system strengthening should be adequately addressed.
Health technology and patient safety

56. Implementation of norms and standards in the area of patient safety progressed during the biennium. Over 500 hospitals in the Region were registered to implement the WHO Hand Hygiene Toolkit by the end of June 2009, and over 50 hospitals are implementing the WHO Safe Surgery Checklist. Patient safety standards were integrated into hospital accreditation programmes in India, Indonesia and Thailand. The Ministry of Health of Bangladesh is rolling out the hand hygiene programme piloted at Chittagong Medical College to district hospitals and scaling it up to a national programme.

57. WHO also supported a one-day session on patient safety at the SASHCON 2008 Conference, with over 500 senior hospital administrators and managers from across India, in November 2008. In the same month, WHO provided support to the First International Conference on Health Promotion and Quality in Health Services in Bangkok, Thailand.

58. In the area of training and education, the South-East Asia Regional Association for Medical Education (SEARAME) disseminated the WHO “Patient Safety Curriculum for Medical Students” to all members. The curriculum will be officially piloted at the Patan Academy of Health Sciences in Nepal (one of six global pilot sites). The curriculum is also being introduced at four medical colleges in Myanmar, the Maulana Azad Medical College in Delhi, and Chulalongkorn University in Bangkok.

59. SEARO has also provided technical assistance to Indira Gandhi National Open University (IGNOU) to develop a Patient Safety
Curriculum for Medical Officers commissioned by DGHS India. WHO has contributed the modules on Medicating Safely and Safe Transfusion of Blood and Blood Products (SEARO/HQ).

60. A one-day training of trainers workshop was organized for participants from Bangladesh, India, Maldives and Thailand in August 2009 following the WHO First Global Patient Safety Challenge’s meeting. SEARO provided technical support to a one-day awareness programme for doctors and nurses on “Clean Care is Safer Care” and “H1N1: Current Scenario” in October 2009 on Global Hand Washing Day, organized by Hospital Infection Society India and Chacha Nehru Bal Chakitsalya (CNBC), a tertiary care children’s hospital in New Delhi.

61. Bhutan was assisted in revising its national policy for quality assurance and standardization in health care, as well as in developing standards for a Safe Medication System.

Organ donation and transplantation

62. Concerned about reports of unethical practices, “transplant tourism” and the sale of organs, WHO organized a regional meeting on the WHO Guiding principles on Organ Transplantation in February 2009, at which Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand were represented.

63. Six countries (Indonesia, India, Thailand, Sri Lanka, Myanmar and Nepal) are undertaking transplantation activity, and will have national plans at varying stages of implementation, and community awareness is being recognized as a major component, with active support from the NGO sector. Xeno-transplantation (transplantation using animal organs) is not permitted.

64. In this region, the demand for organs is many times higher than supply due to high prevalence of end-stage disease, and this huge gap leads to unethical practices; 94% of kidneys and over 70% of livers were from live donors. There are over 220 health facilities performing solid organ transplantation; 65% are in the private sector.

<table>
<thead>
<tr>
<th>Box 5.1: Challenges ahead</th>
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<tbody>
<tr>
<td>- Ethics and implementing regulations</td>
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<tr>
<td>- Safety and quality of practices</td>
</tr>
<tr>
<td>- Availability of organs from deceased donors</td>
</tr>
<tr>
<td>- Public-private partnership</td>
</tr>
</tbody>
</table>
Programme management

1. As per resolution SEA/RC60/R2 of the Sixtieth Session of the Regional Committee, a Subcommittee on Policy and Programme Development and Management (SPPDM) was established in place of the Consultative Committee for Programme Development and Management (CCPDM). As a subcommittee of the Regional Committee, the major objective of the SPPDM is to review the matters relating to programme development and management.
Implementing the Programme Budget for 2008–2009


3. Following the advice of the first and second meetings of the SPPDM, the Regional Office provided support to country offices for improved resource mobilization, and efforts were made towards close coordination with Member States in achieving enhanced implementation—keeping in mind the challenges in mobilization and implementation of voluntary contributions, especially with respect to the additional implementation capacities required, as well as the disparities in funding countries, specific technical programmes or staff.

4. In order to ensure an efficient and effective implementation of PB 2008–2009, the Regional Director extended the delegation of authority to WRs in the Region. Subsequently, monitoring of the implementation of the workplans was intensified to mobilize adequate resources for planned work.

Programme Budget Performance Assessment (PBPA)

5. Programme Budget Performance Assessment (PBPA) for the 2008–2009 biennium was conducted in all countries and the Regional Office, viz., mid-term reporting and end-of-biennium evaluation conducted in the last two months of 2008 and 2009 respectively. Along with assessing key achievements, the PBPA encompassed a review of success factors, impediments, lessons learnt and actions required to improve performance, and analysed financial implementation of the Programme Budget for each Strategic Objective. The PBPA 2008–2009 will guide all levels of the Organization in implementation for the 2010–2011 biennium and planning for the 2012–2013 biennium.

Programme Budget 2010–2011

6. The Regional Programme Budget for 2010–2011 was developed through a process of joint planning between Member States, the Regional Office and WHO headquarters.

7. The programme budget in the SEA Region is formulated through the “bottom-up” approach. Inputs from the countries on priorities
identified in the Country Cooperation Strategies were technically reviewed by the Technical Units at the Regional Office to formulate the regional PB estimates for inclusion in the Organization-wide PB for 2010–1011.

8. The Programme Budget for 2010–2011 was finalized after taking into consideration recommendations of the first SPPDM and the Sixty-first session of the Regional Committee in 2008.

9. The country workplans for 2010–2011 were further refined through a peer review process in August 2009 involving government officials, WHO Country Office Planning Focal Points and PPC staff. This ensured that the expected results and indicators are measurable, concrete and achievable, keeping in mind country priorities.

10. The detailed workplans for 2010–2011 were prepared and submitted at the second meeting of the SPPDM and the Sixty-second session of the Regional Committee for review. The final workplans were approved by the Regional Director in December 2009. The major emphasis in the workplans was to have measurable results and indicators that could reflect the performance of WHO offices in the Region.

11. With substantial changes in the business rules for implementing the budget, workplans and human resource plans, activities in the Planning and Programme Coordination and Governing Bodies (PPC) Unit concentrated on communicating these changes to countries and the Regional Office.

12. With the rollout of the Global Management System (GSM) in January 2010, training sessions were conducted for staff in country offices and the Regional Office for development of workplans in GSM. Efforts were made to increase the capacity of staff members in the Regional Office and country offices in programme management through direct training sessions and learning-by-doing methods.

13. Efforts continued to develop new Country Cooperation Strategies (CCSs) for countries in the Region.

14. New CCSs were finalized for Bangladesh, Myanmar and Thailand. Several of these countries held official CCS launches to ensure wider distribution of the documents, which outline priorities for WHO support to each country over a period of four to six years.

15. A Regional Seminar on Strengthening International Health Coordination (IHC) at the Country Level was held in Indonesia in
February 2008. Heads of international health divisions of Member States of the Region discussed how to strengthen the coordination of international health in their countries. At the seminar, countries shared experiences in international health coordination and outlined specific plans to improve the same.

16. Multicountry activities (MCAs) should be associated with existing Office-Specific Expected Results (OSERs) and products in the country workplans. The role of the Regional Office is to facilitate the implementation of MCAs either in assisting with the preparations of the activities or by providing technical back-up for the activity as needed. However, the decision about the MCAs to be included in each country workplan should rest with the WRs in consultation with MoH counterparts as necessary.

17. In March 2008, the Regional Office Executive Management met all WHO Representatives in the Region to discuss the MCAs for the 2008–2009 biennium. In consultation with ministries of health, WHO country offices were delegated to work together to formulate activities benefiting the countries of the Region. Proposed MCAs were reviewed and selected for further consideration.

**Health Ministers’ Meeting**

18. The Twenty-sixth Meeting of the Ministers of Health of countries of the WHO South-East Asia Region was held in New Delhi, India, on 8-9 September 2008. His Excellency Mr Pranab Mukherjee, Minister for External Affairs, Government of India, delivered the inaugural address, which highlighted the Government of India’s commitment to socioeconomic development, particularly health sector programmes.

19. Recognizing that global warming and climate change pose a major threat to public health, the health ministers committed, in the New Delhi Declaration on the impact of climate change on human health, to implement the World Health Assembly resolution WHA 61.19 on climate change and health, and the regional framework for action to protect human health, to develop effective and efficient strategies and measures relating to climate change.

20. On the Millennium Development Goals, the health ministers agreed to sustain high-level commitment to strengthening health
systems using the revitalized primary health care (PHC) approach in collaboration with WHO.

21. The Twenty-seventh Meeting of the Ministers of Health was held in Kathmandu, Nepal, during 7-8 September 2009. The Right Honourable Mr Madhav Kumar Nepal, Prime Minister, Federal Democratic Republic of Nepal, delivered the inaugural address at the joint inauguration of the Health Ministers’ Meeting and the Sixty-second session of the WHO Regional Committee for South-East Asia.

22. The meeting adopted the Kathmandu Declaration on Protecting Health Facilities from Disasters. The declaration stresses the need to optimize the use of advances in technology and to apply current good practices to scale up efforts to strengthen the structural, nonstructural and functional aspects of protecting and increasing the resilience of health facilities.

**Technical briefings**

23. The practice of organizing technical briefings for Member States/Executive Board members before the meetings of the World Health Assembly and the WHO Executive Board has been appreciated by Member States of the Region. This has helped them keep abreast with the progress made in respect of various health-related agenda items and if need be take a unified stand on issues affecting the Region.

**Visits of high-level delegations to the Regional Office**

24. A high-level delegation headed by Prof. Dr Syed Modasser Ali, Adviser to the Prime Minister of Bangladesh on Health and Family Welfare Affairs, visited the Regional Office in April 2009 and met senior management as well as the Department of Health Systems Development to discuss improving primary health care by establishing community health clinics (CHC).

25. H.E. Mr Nimal Siripala de Silva, Minister of Healthcare & Nutrition, Sri Lanka, visited the Regional Office on his way to Chandigarh, India, to participate at the Annual Convention of the International Medical Sciences Academy there in October 2009. His Excellency discussed with some senior staff members the WHO collaborative programme in Sri Lanka.
Governing bodies and policy dialogue

Regional Committee

26. The Sixty-first Session of the Regional Committee for South-East Asia was held in the Regional Office, New Delhi, India, from 8-11 September 2008, while the Sixty-second Session was held in Kathmandu, Nepal, from 7-10 September 2009. Besides representatives of all the 11 Member States of the Region, the Director-General and representatives of other UN agencies, NGOs having official relations with WHO and observers attended the sessions.

27. In these two sessions, the Committee reviewed the Report of the Regional Director on the Work of WHO in the South-East Asia Region covering the periods 1 July 2007 to 30 June 2008 and 1 July 2008 to 31 August 2009, respectively. Six resolutions and three decisions were adopted in the Sixty-first Session and seven resolutions and three decisions in the Sixty-second Session.

Public information and advocacy

28. Strategic communication is considered an important tool in advocacy, building awareness, disseminating information, and working together with all stakeholders for achieving common goals. Work to strengthen strategic communication continued.

29. The Regional Office streamlined its communication with WHO communication officers in the Region by establishing the SEA Region Communication Network (SCN). The network helped strengthen internal and external communication between the Regional Office and Member States. The Regional Office coordinates advocacy and information dissemination during emergencies and outbreaks, as well as key advocacy events such as World Health Days and sessions of the Regional Committee through this network.

30. One of the key objectives of the SCN network is to constantly upgrade the skills and capacity of WHO communication officers in the Region. In 2008-2009, WHO communication officers received training on: (i) basics of photography; (ii) communicating effectively with the media; and (iii) communicating through social networking websites.

31. A workshop was organized from 22-24 April 2009 at Kathmandu, Nepal to build capacity in risk communication in the context of the IHR, in which WHO communication officers from the Region and
communication experts from ministries of health participated. The workshop turned out to be very timely as the Pandemic (H1N1) 2009 news broke out on its last day. As a result, WHO communication officers and ministries of health were able to respond in a coordinated manner to the Pandemic (H1N1) 2009.

**Communication response to the Pandemic (H1N1) 2009**

32. The Member States, partners and other stakeholders were kept updated through regular communication in the form of daily situation reports, talking points, web updates and press releases, etc. Such communication was shared with partners, Embassies and other UN agencies.

33. During the pandemic, a number of information, education and communication (IEC) materials were produced to help Member States disseminate key messages to the public.

34. Training was conducted for spokespersons in WR offices in November 2009, which was also extended to WHO Professional staff. Furthermore, risk communication training is planned for Member States during the 2010-2011 biennium in response to the need expressed by them.

35. The following television programmes were produced in 2008-2009:

- **Public service announcements**: Short, 30-second TV spots with public health messages were produced and aired on TV stations across the Region, covering the following aspects of public health: (i) Safe hospitals save lives; (ii) Handwashing and coughing etiquette for prevention of Pandemic (H1N1) 2009; and (iii) World Breastfeeding Week message.

- **Documentaries**: A 26-minute documentary on water, sanitation and climate change titled “Deeply superficial”. The documentary traced the journey of the river Ganges and its tributaries in three Member States: Bangladesh, India and Nepal. It focused on water contamination and its health effects, and was screened in several Member States on television networks. Furthermore, a film commemorating 30 years of smallpox eradication was also produced. It documented the testimony of key players in the eradication campaign, including the testimony from Ms Rahima Bano, the last smallpox patient in the SEA Region.
General management

The Global Management System

1. The Global Management System (GSM) is intended to be used as an effective managerial tool to increase the efficiency of the work of the Organization. The GSM “Go Live” represents an important milestone for the WHO SEA Region. The system is intended to eventually enhance management efficiency of the Organization, particularly the management of WHO collaboration with its Member States. This will enable the administrative processes to better support the technical work at all levels, especially in country offices.
2. Staff in the Regional Office and in country offices contributed actively in the GSM preparedness activities and worked tirelessly to make the system a success. Change management strategies and project plans were developed to create an empowering environment for a successful implementation of the GSM. Activities under the Change Management Plan were implemented to reorient people, processes and systems towards better management, using a network of change agents training on soft skills, including behavioural skills change management and stress management were also conducted to prepare GSM trainers-cum-change agents.

3. Role-mapping workshops were conducted at country offices and in the Regional Office, where the GSM roles were mapped with the staff based on their respective profiles. The outcome of these activities was intended to define the GSM roles to staff in a timely manner.

4. Cross-programme cohesion in the administration area was ensured through an effective team-oriented approach to manage the business changes within the context of GSM by resolving cross-functional challenges. Regular collaborative meetings were held with headquarters. Several cross-cutting Standard Operating Procedures (SOPs) were developed. The Regional Director’s Delegation of Authority to WRs, including accountability framework, was developed to manage WHO’s collaborative programmes at country level.

5. The GSM training sessions were completed successfully for the Regional Office and country office users as per the Regional GSM Training Strategy and Plan. Part I of the Training Plan focused on preparedness of GSM users-cum-change agents, while Part II focused on end-users’ training. A network of 70+ trainers-cum-change agents was established including the Regional Office and country office staff.

6. Various GSM communication sessions were organized on a regular basis for Regional Office and WR offices’ staff on the key procedural changes triggered by the GSM. Communication with ministries of health counterparts and Member States proved beneficial as it helped to raise awareness on the GSM “Go Live” and target lead time for the important transactions relevant to Member States. A regional support strategy was established, which included a Regional Service Desk in coordination with the Global Service desk, GSM Clinics and other support channels.
7. The information and communication technology (ICT) infrastructure was upgraded in close collaboration with teams at headquarters and country offices, including the connectivity and communication capability to support the GSM use.

Human resources

8. Facing up to the many complex health challenges in the Region, human resources (HR) are at the core of the coordinated support provided to Member States, and continue to function in a complex and changing environment. In order to attract and motivate highly qualified personnel, HR reforms continue to be high on WHO’s agenda.

9. To make the recruitment processes simple, qualitative, time-effective and transparent, the selection guidelines for Professional staff were revised twice with the view to having a more transparent selection process.

10. The exercise of preparing the Roster of WHO Representatives (WRs) continued. Meetings of Regional Personnel Officers from all regions, as well as from the HR Department, WHO headquarters, Geneva, were arranged through video conferences in order to jointly prepare shortlists of potential candidates.

11. A training workshop on Personnel Management was organized from 3-6 November 2009 in Manila, Philippines with country offices, on various updates regarding HR policy and procedures.

12. As of 31 December 2009, the total staff strength of the Region was 555, consisting of 133 International Professional (P), 45 National Professional Officers (NPOs) and 377 General Service (GS) staff. The SEA Region has a diverse professional workforce, with 39 nationalities; 72 (54%) Professional staff come from this Region. The overall staffing strength in the Region increased gradually over the last six years with a slight decline of 3% in 2008, as illustrated in Figure 7.1.
13. The roster of experts in different technical/administrative areas was developed to ensure qualitative selection and accelerate recruitment of Temporary International Professionals (TIPs). Twenty-seven “roster” vacancy notices (VNs) were issued through e-recruitment and additional four VNs were posted by technical units concerned on their respective websites for wider distribution. A total of 25 TIPs were recruited through this mechanism.

14. During the period under review, 41 Professional staff, 19 NPOs and 125 GS fixed-term staff were selected. In addition, a total of 486 temporary staff (P/ NPO/GS) were recruited in the Region.

15. Nine positions at Grades P6/D1 were vacated during the period 1 January 2008 to 31 December 2009 due to separation (retirement and death, etc.) or reassignment. Four positions were filled, one position was abolished and four positions were vacant as of 31 December 2009.

16. Various HR processes are being reviewed to ensure their alignment with the requirements of the GSM. Once the processes in the GSM are streamlined, it will prove to be a time- and cost-effective mechanism.
Staff development and learning

17. The core purpose of Staff Development and Learning (SDL) activities is to build capacity and enhance abilities of staff. Staff development and learning operates at two levels: as an organizational development unit, and to assist individual staff development.

18. During the period under review, a range of staff development activities were undertaken including orientation programmes, language training, technical workshops, women development; resource mobilization, and personnel management, to name a few. SDL retreats were organized in almost all country offices. Furthermore, “distance learning” was incorporated as an approach to increase access to learning resources. Several online programmes were administered, ranging from courses in biostatistics to online language-learning initiatives.

19. The SDL activities were aligned with the six learning priorities as determined by the Global Learning Committee: Management and Leadership; Building Core Competencies; Technical Skills; Language Training: Induction and Orientation; and Learning Excellence. The SEA Region Learning committee met twice in the year 2009 (June and November). Table 7.1 below shows the allocation of expenditure against specific learning priorities:

<table>
<thead>
<tr>
<th>Learning priority</th>
<th>Expenditure (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management and Leadership</td>
<td>241,564</td>
</tr>
<tr>
<td>Building Core Competencies</td>
<td>71,607</td>
</tr>
<tr>
<td>Technical Skills</td>
<td>123,217</td>
</tr>
<tr>
<td>Language Training</td>
<td>17,355</td>
</tr>
<tr>
<td>Induction and Orientation</td>
<td>50,767</td>
</tr>
<tr>
<td>Learning Excellence (Retreats)</td>
<td>94,055</td>
</tr>
</tbody>
</table>

| Total                                   | 598,565           |

20. The following graph details the percentage of the total SDL expenditure in respect of individual country offices:
Budget and financial management

Implementation and expenditures

21. The SEA Region ended the 2008–2009 biennium with total resources of US$ 425 million, which showed an increase of US$ 1.7 million (0.4%) over the previous biennium’s figure of US$ 423.3 million. At the close of the 2008–2009 biennium, the Region had fully committed its Assessed Contribution (AC) allocation of US$ 102.9 million and had expended US$ 260.3 million of Voluntary Contributions (VC) received from donors. The total expenditure increased by 14% over the previous biennium’s figure of US$ 318.3 million to US$ 363.2 million. Implementation for 2008–2009 are shown by Budget Centre and by Strategic Objective in Annexes 1 and 2, respectively.

Voluntary versus Assessed Contribution(s)

22. The VC resources for the Region declined marginally to US$ 322 million as compared to US$ 326 million in December 2007. About 76% of the total resources for the Region were funded by VC, while AC accounted for the balance 24%. On the expenditure side, 72% of the Region’s expenditure (total US$363.2 million) were financed using VC, with AC funding the balance 28%. The pattern continued the trend seen previously too in the Region and experienced across the
Organization as a whole. The figure below shows the trend in respect of the regional expenditure over the last few bienniums.

**Figure 7.3:** Assessed Contributions (AC) versus Voluntary Contributions (VC) expenditure: SEA Region

23. For 2010–2011, the Region’s AC was reduced marginally by 0.6%, to US$ 102.3 million. The SEA Region continues to allocate more of its AC to countries than any other region. The VC budget for the Region stands at US$ 437 million, further increasing its reliance on VC to fund the regional Programme of Work. Annexes 3 and 4 provide information on the distribution of resources based on approved workplans.

24. The Regional Office successfully closed its books for the 2008-09 biennium under the “legacy financial system” with 100% implementation of AC, and made a full transition to the Global Management System (GSM) with effect from 1 January 2010. The Region continues to strengthen capacity to support country offices with the goal to deliver efficient support services towards effective financial management of programme implementation. However, it is still confronted with some serious challenges. These include effective monitoring and efficient implementation of VC; strengthening competencies within the GSM; and enhancing its ability to quickly adapt to a business environment in which it has to rely greatly on unpredictable and largely specified VC.
Informatics and infrastructure services

25. ICT is a critical success factor for WHO’s work. During the period under review, the strategic role of ICT was further extended across the Regional Office, WR offices, WHO field offices and Member States by providing efficient and effective ICT services to staff as well as technical advice to Member States. The regional ICT strategy was implemented with a view to organizational development, country-specific requirements and cost-effectiveness of ICT operations at the country level.

26. Significant contributions were made for development of global ICT strategies and policies. The existing Regional Office policies, procedures and guidelines were updated and made available on the Regional Office Intranet.

27. The ICT offers great potential to improve health services and systems. Regular advice was provided for ICT infrastructure development in the health sector including support for emergency operations. Member States in the SEA Region were provided with advice on the ICT aspects of e-Health, and on public-private partnership in the ICT sector. The “Global survey on e-Health” pilot was completed in Thailand. The Ministry of Health, Maldives was advised to finalize the donor agreement with the World Bank for setting up telemedicine facilities. As per the request received from the Ministry of Public Health, DPR Korea, a needs assessment for health and ICT readiness survey was conducted to establish an e-health project. The use of
the Geographical Information System (GIS) was further promoted and supported in the Region as GIS applications play a major role in decision-making by strengthening data analysis and presentation and dissemination of health data. A GIS training on “Health Mapper” was conducted for ministries of health of Bangladesh and Indonesia.

28. In order to ensure reliable, secure and cost-effective ICT solutions to meet the changing needs of the Organization, ICT infrastructure in the Regional Office and in all country offices has been upgraded, including end-user devices, and connectivity and communication capability to use the GSM. The centralized data storage solution (SAN) has been implemented in the Regional Office. A solution for remote access of the GSM was implemented in the Regional Office, and in the country offices for Bangladesh, India, Indonesia, Sri Lanka and Thailand.

29. All country offices in the Region are now connected to the Global Private Network (GPN). Furthermore, the GPN links in all offices have been upgraded to higher bandwidths, except for Sri Lanka where a terrestrial link is under implementation to replace the current VSAT link. Secured VPN tunnels have been deployed to serve as a back-up for GPN connectivity in Bangladesh, India, Indonesia, Maldives and Sri Lanka, and configurations are under way for other country offices. The GPN connectivity has been extended to field offices in Bangladesh, India and Nepal; GSM is also accessible.

30. Staff productivity was further improved through appropriate ICT tools and techniques across the Region. Initiatives were undertaken for capacity building at country offices. Online tools were implemented to promote effective collaboration and user support at remote locations including at country offices. Sharepoint portals were developed and implemented for programmes as per their requirements. A “blog” was established for GSM trainers as a collaborative workspace. A “Go To Meeting” software tool was implemented and support provided on its use in order to further promote online collaboration. Regular ICT training and proximity services were provided to the SEA Region users. Services for electronic archival of documents were managed and support provided as per user requirements. In order to further strengthen the ICT capacity for using the GSM, a training programme on “ICT essentials for GSM” was conducted for the Region’s users. Cost-effective ICT solutions were delivered to automate processes and enhance analytical and reporting capabilities of users including development of new applications and enhancement/maintenance of existing systems in view of business changes. Remote support was
also provided to the Regional Offices for the Eastern Mediterranean and Europe for their data-conversion activities.

**Procurement services**

31. The Regional Office procurement services continued to facilitate timely and effective supply and logistic support to projects and technical/health programmes for varied activities in the Region, including major capital developments/refurbishment of the Regional Office.

![Essential medical supplies were procured and promptly despatched to requesting Member States.](image)

32. Drugs, vaccines, diagnostic test-kits, long-lasting insecticidal nets, personal protective equipment (PPE), reagents, laboratory supplies and hospital equipment comprised the largest portion of procurements, amounting to US$ 53.67 million or 61% of the total procurements made by the Regional Office.

33. Emergency supplies were arranged on a priority basis for cyclone-affected areas in Myanmar; flood-affected areas in Bangladesh and Nepal; and for the rabies outbreak in Bali, Indonesia. In the Regional Office, the Emergency and Humanitarian Action (EHA) unit worked in close collaboration with the Medical Supplies Unit (MSU), and with the DSE subunit in Bangkok, Thailand to maintain IEHK stockpiles for emergencies such as earthquakes and tsunamis, etc.
34. As part of emergency preparedness and response related to avian influenza, the Regional Office maintained a stockpile of Tamiflu and PPEs with the aim to meet any immediate requirement in case of a pandemic. It also procured these items for other UN agencies. During the H1N1 pandemic, the Regional Office procured and delivered emergency supplies to Member States on utmost priority.

35. During the reporting period, the total of supplies procured for Member States and the Regional Office amounted to US$ 88.2 million, out of which supplies worth US$ 5.9 million were procured using Regular Budget funds, and supplies worth US$ 82.3 million were procured with Voluntary Contributions.

36. Regarding procurements from “other sources”, purchases made for individual countries on a reimbursable basis amounted to US$ 2.28 million. Requests were received for procurement of drugs, vaccines, LLINs, diagnostic test-kits, water purifying chemicals and other items under the “reimbursable” mechanism. Bangladesh, Bhutan, India, Maldives, Nepal, Sri Lanka and Thailand were supported under the “reimbursable” procurement mechanism.

**Procurement under the Global Management System**

37. The GSM was successfully launched in the Regional Office on 1 July 2008 on a transitional basis. The Regional Procurement Office has been making optimal use of the system during the transition phase, despite some inherent weaknesses. The GSM “Go Live” took place during the second week of January 2010. Initially, as expected, the users faced a few problems in processing requests through the GSM. But within a few weeks, the MSU team was able to overcome these impediments, and the GSM procurement module began to function smoothly.

**Administrative services**

38. During the period under review, Administrative Services undertook the practical implementation of the Regional Office premises strategy adopted in the preceding biennium. An access audit was undertaken in the Regional Office and work was initiated to align the access
facilities of offices with the principles of the Convention on the Rights of Persons with Disabilities.

39. In response to the challenge of making WHO facilities climate-neutral and environmentally sustainable, an energy audit was undertaken at the Regional Office. To enhance environmental performance, the following installations were made:

- a sewage treatment facility;
- stormwater drains;
- an energy-efficient air-conditioning system;
- roof insulation;
- a solar hot water system;
- solar panels (photovoltaic) to generate electricity; and
- a composter.

**Security**

40. The Regional Field Security Office continued to provide operational security support to the Regional Office and all WHO country offices throughout the SEA Region.
41. During the period under review, the emphasis was on ensuring that all WHO offices were compliant with MOSS, and that staff residential security was compliant with MORSS (Minimum Residential Security Standard).

42. Support was provided to several country offices during periods of heightened security, backed with close interagency cooperation. Security support was provided to the polio programme in India through training and security assessments.

43. Continued emphasis was placed on good training and security programmes that enable staff to maintain their personal security awareness and understand the United Nations security management system and framework of accountability.

44. The tragic events of 26 November 2008 in Mumbai, India resulted in the UN Security Phase changing to Phase 1 (Precautionary Phase) in India and further highlighted the need for sound security management, including preparedness, risk mitigation and business continuity, together with good interagency communication.

45. The key issues and challenges that require priority attention relate to emergency preparedness, and to ensuring that an effective and efficient operating security standard is met throughout the Region.
Annexes
### Annex 1

**Budgetary implementation, 2008-2009 by budget centre**

*All sources of funds (as at 31 December 2009)*

*Expressed in US $*

<table>
<thead>
<tr>
<th>Budget Centre</th>
<th>Planned</th>
<th>Available Resources</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AC</td>
<td>VC</td>
<td>AC</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>10 889 807</td>
<td>39 719 126</td>
<td>10 889 807</td>
</tr>
<tr>
<td>Bhutan</td>
<td>3 009 997</td>
<td>4 230 528</td>
<td>3 009 997</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>13 801 877</td>
<td>93 038 920</td>
<td>13 801 877</td>
</tr>
<tr>
<td>India</td>
<td>9 289 216</td>
<td>57 402 114</td>
<td>9 289 216</td>
</tr>
<tr>
<td>Indonesia</td>
<td>6 427 031</td>
<td>34 778 271</td>
<td>6 427 031</td>
</tr>
<tr>
<td>Maldives</td>
<td>2 320 137</td>
<td>3 675 534</td>
<td>2 320 137</td>
</tr>
<tr>
<td>Myanmar</td>
<td>7 532 137</td>
<td>46 782 779</td>
<td>7 532 137</td>
</tr>
<tr>
<td>Nepal</td>
<td>7 978 677</td>
<td>19 119 542</td>
<td>7 978 677</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>5 501 160</td>
<td>10 694 052</td>
<td>5 501 160</td>
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<tr>
<td>Thailand</td>
<td>6 786 920</td>
<td>8 933 254</td>
<td>6 786 920</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>2 238 541</td>
<td>6 547 828</td>
<td>2 238 541</td>
</tr>
<tr>
<td><strong>Country Total</strong></td>
<td><strong>75 775 500</strong></td>
<td><strong>324 921 948</strong></td>
<td><strong>75 775 500</strong></td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td>4 119 719</td>
<td>28 931 500</td>
<td>4 119 719</td>
</tr>
<tr>
<td>Administration and Finance</td>
<td>4 877 116</td>
<td>15 767 484</td>
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<tr>
<td>Office of Director Programme Management</td>
<td>1 255 642</td>
<td>1 913 472</td>
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</tr>
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<td>1 268 493</td>
<td>6 310 133</td>
<td>1 268 493</td>
</tr>
<tr>
<td>Emergency and Humanitarian Action</td>
<td>840 000</td>
<td>4 911 000</td>
<td>840 000</td>
</tr>
<tr>
<td>Family and Community Health</td>
<td>2 658 856</td>
<td>11 701 000</td>
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<tr>
<td>Health Systems Development</td>
<td>5 340 408</td>
<td>10 441 000</td>
<td>5 340 408</td>
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<tr>
<td>Immunization and Vaccine Development</td>
<td>544 442</td>
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<td>Non-communicable Diseases and Mental Health</td>
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<td>9 061 000</td>
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<tr>
<td>Office of Regional Director</td>
<td>1 381 122</td>
<td>2 522 663</td>
<td>1 381 122</td>
</tr>
<tr>
<td>Sustainable Development and Healthy Environments</td>
<td>1 949 702</td>
<td>2 693 000</td>
<td>1 949 702</td>
</tr>
<tr>
<td><strong>Regional Office Total</strong></td>
<td><strong>27 123 000</strong></td>
<td><strong>112 089 252</strong></td>
<td><strong>27 123 000</strong></td>
</tr>
<tr>
<td><strong>SEAR Total</strong></td>
<td><strong>102 898 500</strong></td>
<td><strong>437 011 200</strong></td>
<td><strong>102 898 500</strong></td>
</tr>
</tbody>
</table>
## Annex 2

### Budgetary implementation, 2008-2009

by strategic objective

**All sources of funds**
*(as at 31 December 2009)*

**Expressed in US $**

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Planned</th>
<th>Available Resources</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AC</td>
<td>VC</td>
<td>AC</td>
</tr>
<tr>
<td>1. To reduce the health, social and economic burden of communicable diseases</td>
<td>9 216 500</td>
<td>157 376 000</td>
<td>9 216 500</td>
</tr>
<tr>
<td>2. To combat HIV/AIDS, tuberculosis and malaria</td>
<td>8 863 000</td>
<td>80 633 500</td>
<td>8 863 000</td>
</tr>
<tr>
<td>3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries</td>
<td>7 209 500</td>
<td>8 731 000</td>
<td>7 209 500</td>
</tr>
<tr>
<td>4. To reduce morbidity and mortality and improve health during key stages of life including pregnancy, childbirth and neonatal period, childhood and adolescence and improve sexual and reproductive health and promote active and healthy ageing for all</td>
<td>7 418 500</td>
<td>31 750 000</td>
<td>7 418 500</td>
</tr>
<tr>
<td>5. To reduce the health consequences of emergencies, disasters, crises in conflicts, and minimize their social and economic impact</td>
<td>4 218 000</td>
<td>60 614 000</td>
<td>4 218 000</td>
</tr>
<tr>
<td>6. To promote health and development, and prevent or reduced risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex</td>
<td>4 100 500</td>
<td>14 188 700</td>
<td>4 100 500</td>
</tr>
<tr>
<td>7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches</td>
<td>919 000</td>
<td>3 580 000</td>
<td>919 000</td>
</tr>
<tr>
<td>8. To promote a healthier environment, intensified primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health</td>
<td>5 743 500</td>
<td>6 782 000</td>
<td>5 743 500</td>
</tr>
<tr>
<td>9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development</td>
<td>2 623 000</td>
<td>7 323 000</td>
<td>2 623 000</td>
</tr>
<tr>
<td>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research</td>
<td>24 967 500</td>
<td>28 231 000</td>
<td>24 967 500</td>
</tr>
<tr>
<td>11. To ensure improved access, quality and use of medical products and technologies</td>
<td>3 501 500</td>
<td>7 204 000</td>
<td>3 501 500</td>
</tr>
<tr>
<td>12. To provide leadership, strengthen governance and foster partnership in collaboration with countries in order to fulfill the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work</td>
<td>8 327 000</td>
<td>6 582 315</td>
<td>8 327 000</td>
</tr>
<tr>
<td>13. To develop and sustain WHO is a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively</td>
<td>15 791 000</td>
<td>24 015 685</td>
<td>15 791 000</td>
</tr>
</tbody>
</table>

**Total**

|                      | 102 898 500 | 437 011 200 | 102 898 500 | 322 149 957 | 102 898 179 | 260 341 080 |
As the lead UN agency in international health development, WHO has been collaborating with its Member States in the South-East Asia Region to strengthen national capacity in several areas of priority interest. Accounting for nearly one fourth of the global population the Region also carries a heavy burden of communicable and noncommunicable diseases. These factors are further compounded by inadequate resources and pose a unique challenge, which are being addressed by policymakers in the Region.

This biennial report on the Work of WHO in the South-East Asia Region for the period 1 January 2008 – 31 December 2009, covers the major areas of WHO collaboration, highlighting the achievements, challenges and the way forward. This report will be found most useful for all those interested in health development in the Region.